

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

290-4200

1. FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8102322

1. DECEASED NAME (TYPE OR PRINT) Blanche W. Adams			2a. DATE OF DEATH MONTH DAY YEAR 1/17/81			2b. HOUR 4:40 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR NOV. 25 1887		6. AGE (IN YEARS LAST BIRTHDAY) 93			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home		
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 17 Parkside Road,					
14. FATHER'S NAME FIRST MIDDLE LAST George W. Wright				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emza Jane Gray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 490-30-7324		17. INFORMANT (daughter) ADDRESS M. Elizabeth Denham- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cong 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) 7 mo							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 1980 to 1/17 19 81 , that (I) (we) first saw the deceased alive on 1/15 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. G. LEVIN DEGREE M.D.						22c. DATE SIGNED 1/17/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN						22e. ADDRESS 8630 FENNER ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.						25a. DATE REC'D. BY REGISTRAR JAN 22 1981		25b. REGISTRAR'S SIGNATURE Patrick McBrady	

2 2 0 5 0 1 8

18 11 15 17

28

7

18 11 15 17 28 29 30 31

12 10 11

18 11 15 17 28 29 30 31

18 11 15 17 28 29 30 31

18 11 15 17 28 29 30 31

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 2 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nelle PIATT ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 1 14 81		2b. HOUR 8:35 PM	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 - 9 - 92		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Asst. Currator	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST John Platt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Mc Conaha			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 271 10 1254D		17. INFORMANT Rockville, Md. E. James Adams 12809 Spring Dr.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) A. V. conduction defect 5405 DUE TO, OR AS A CONSEQUENCE OF (c) an aortic regurgitation 10405 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 130 HRS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senility						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov 1972 to 1981 , that (I) (we) lost no the deceased on 1/16/81 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE John M. Wynn				DEGREE no		22c. DATE SIGNED 1/14/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Wynn				22e. ADDRESS 7801 NINFAVE AVE Bethesda, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/16/81		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25. REGISTRAR'S SIGNATURE 1/16/81		
1331 Rockville Pike Rockville, Maryland						

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar, each with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



Illinois

USA

x

Montgomery

Cincy

Brooks Grove Hospital Home

199 Collins Ave.

Montgomery Rockville

John

Place

Barry

So Conna

no

271 10 1982

James Adams 1982 North Wt.

271 Rockville, Maryland
Lynch Wheeler Funeral Home, Inc.
Greenfield, Maryland
Greenfield, Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 2 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose Marie Agolia			2a DATE OF DEATH MONTH DAY YEAR 1 11 81		2b HOUR 1 P.M.												
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1889		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS HOURS MIN.							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bd. of Ed. (N.Y.)		12b. KIND OF BUSINESS OR INDUSTRY Queen's Cafeteria									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.						13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18601 Walker's Choice Rd.					
14 FATHER'S NAME FIRST MIDDLE LAST John - Curcie			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence - Agolia			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -						16b SOCIAL SECURITY NO 080-16-4314		17 INFORMANT Eleanor Terraro		18 ADDRESS 18601 Walker's Choice Rd. Gaithersburg, Md. 20760	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr. 10 yrs																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Renal Failure																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 614/80 19 to 4/11/81 19			21g. I certify that (I) (this hospital) attended the deceased from 6/14/80 19 to 4/11/81 19, that (I) (we) last saw the deceased alive on 1/8/81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22a. SIGNATURE Henry C. Scruggs MD			22b. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SCRUGGS MD			22c. DATE SIGNED 1/11/81			22d. ADDRESS 5413 Cedar Lane Bethesda Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 14, '81			23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Kings N.Y.								
24 FUNERAL DIRECTOR Laborable Sandison 316 E. Diamond Avenue Gaithersburg, Md.						25a. DATE WHEN DEATH WAS REGISTERED 1/11/81						25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Billy E FIRST D. ALEXANDER MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR 1-22-81		2b. HOUR 6:40P.M.
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Mar. 20, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mil. Personnel Sp.	12b. KIND OF BUSINESS OR INDUSTRY Dept. Army	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Calvert 13d. CITY OR TOWN Lusby			13e. STREET ADDRESS Box 157		
14. FATHER'S NAME FIRST Earnest MIDDLE Drake LAST Bolden		15. MOTHER'S MAIDEN NAME FIRST Ann MIDDLE Bolden LAST Bolden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-16-9519		17. INFORMANT husband ADDRESS same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF PERICARDIAL TAMPONADE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1749 (b) PERICARDIAL TAMPONADE DUE TO, OR AS A CONSEQUENCE OF ALCOHOLIC CARDIOMYOPATHY (c) ALCOHOLIC CARDIOMYOPATHY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 1 hr 6 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 P.M. 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 81 , to 1/22 , 19 81 , that (I) (we) last saw the deceased alive on 1/22 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) examine the body after death.					
27b. SIGNATURE E. S. LEVINE M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/22/81
27d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVINE		27e. ADDRESS 8C 30 FENNER ST			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 24, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE Virginia		23e. DATE REC'D. BY REGISTRAR JAN 27 1981			
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd. W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Robert H. Bandy			

BP

(M)

X

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 2 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Francis ALEXANDER			2a. DATE OF DEATH MONTH DAY YEAR January 21 1981		2b. HOUR 4:05P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 20 1906		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Army		12b. KIND OF BUSINESS OR INDUSTRY Officer
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Virginia	13b. COUNTY Arlington	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4636 North 24th St.	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Duff Alexander		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bullock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1941-61	17. INFORMANT ADDRESS Mrs. Susan C. Alexander See item 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Panlobular emphysema; focal bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4920 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) _____ DUE TO, OR AS A CONSEQUENCE OF		
(c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from Dec. 11 19 81 to Jan. 21 19 81, that (I (we) last saw the deceased alive on Jan. 21 19 81, and that in (my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) told) (did not) view the body after death.					
22b. SIGNATURE Mitchell Fink MD				22c. DATE SIGNED Jan. 23 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell Fink, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan 26, 1981	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.
24. FUNERAL DIRECTOR NAME Murphy Arlington Funeral Home Arlington, Va.		25a. DATE REC'D. BY REGISTRAR JAN 27 1981	25b. REGISTRAR'S SIGNATURE [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



22-

12

1 - FOR STATE REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2800

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA ANN ANASTASI			2a. DATE OF DEATH MONTH DAY YEAR Jan 21 81		2b. HOUR A 10:39M
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR July 28 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON		12b. KIND OF BUSINESS OR INDUSTRY J.C. PENNY CO.
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1948 Seminary Place
14. FATHER'S NAME FIRST MIDDLE LAST H. M. Spring		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE HUGHES		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 404-20-1540		17. INFORMANT SON		ADDRESS 680 COLLEGE PARK WAY ROCKVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma ovary					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 7 months 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN. 19 78 to JAN 21, 19 81 , that (I) (we) lost saw the deceased alive on JAN 16, 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hubert J. Alpert		DEGREE MD		22c. DATE SIGNED JAN. 21, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, M.D.		22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/24/81	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR JAN 22 1981		25b. REGISTRAR'S SIGNATURE Robert M. [Signature]
ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901					

TRANSACTIONS

959

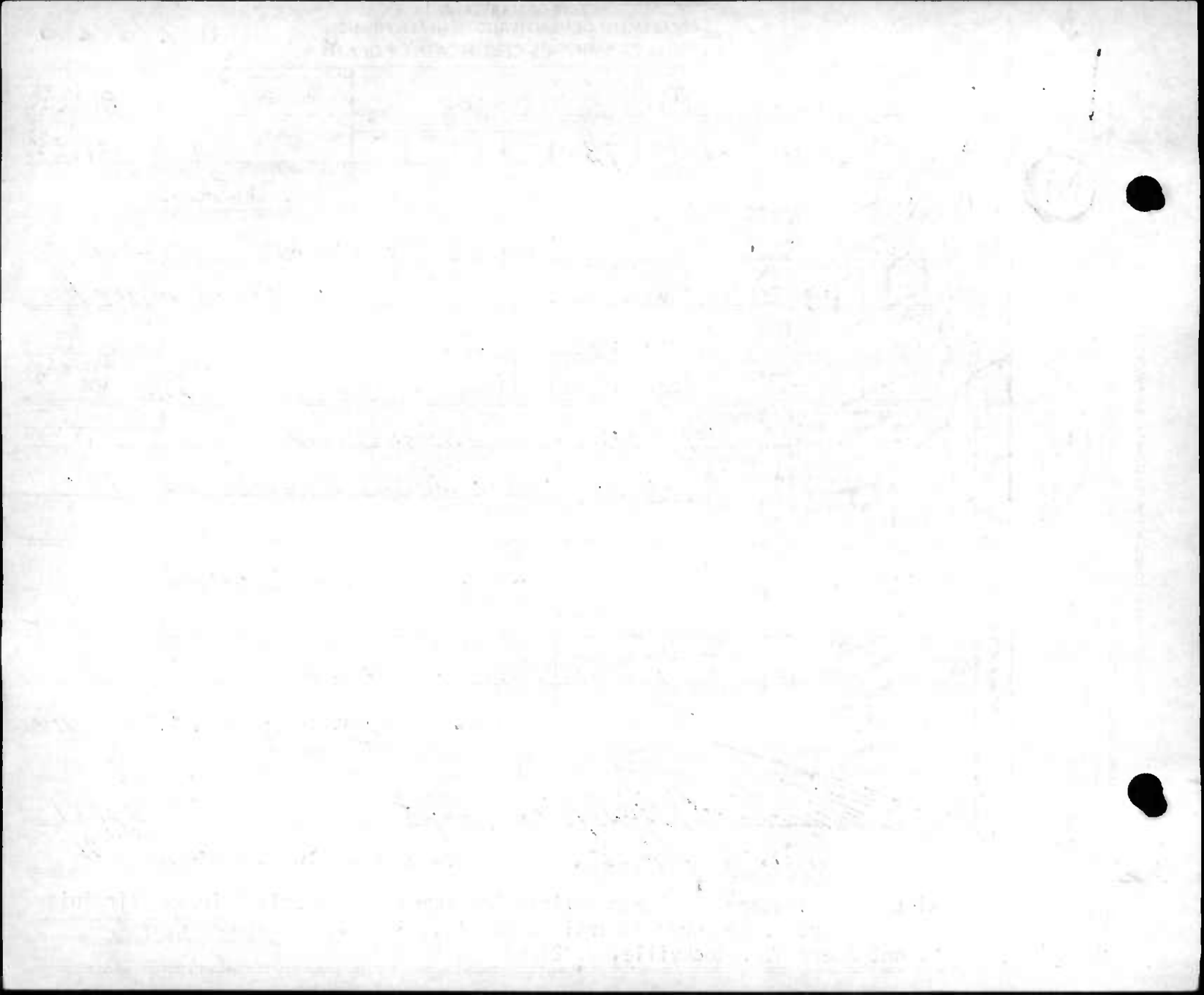
13 XXX SS v.107

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02328	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas M. Anderson										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 3 1981	
2. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 10 28 02		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JUDGE			12b. KIND OF BUSINESS OR INDUSTRY LAW	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 39 W. MONTGOMERY AVE			
14. FATHER'S NAME FIRST MIDDLE LAST George M. Anderson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Vinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-34-3324		17. INFORMANT Thomas M. Anderson Jr.				ADDRESS 30 Court House Sq., Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4V's										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). FRACTURE LEFT HIP FRACTURE LEFT HUMERUS											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR P.M. 1 1 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL AT HOME					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN STATE 39 W. MONTGOMERY AVE. ROCKVILLE MONT. MD.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C. Mayle				TITLE (SPECIFY) M.D. Dept				DATE SIGNED 1/31/81			
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE				ADDRESS 8200 Wisconsin Ave Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1981 January 4		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey						ADDRESS 300 W. Montgomery Ave., Rockville, Md. 20850		DATE REC'D BY REGISTRAR JAN 12 1981		REGISTRAR SIGNATURE	

BP

DHMH - 17
(VR A15 ME (1))
30M 7/73



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 2 9

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) PAULINE (NMN) ARAVANIS		3. DATE OF DEATH MONTH DAY YEAR JAN/15/81		4. HOUR 6:50 P.M.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR JULY 6, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Olney	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Business Associations		13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST COSTAS ARAVANIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARGYRO LA FRANCIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-18-5354	
17. INFORMANT ADDRESS 13206 Kenting St.,		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GRAM NEGATIVE SEPTICEMIA 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ANAPLASTIC CARCINOMA LUNG (SMALL CELL) DUE TO, OR AS A CONSEQUENCE OF (c) WITH METASTASIS -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 4/28/80 19 81 , to 1/15/81 19 81 , that (I) (we) lost saw the deceased alive on 1/16 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE W. W. Chambers DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 1/16/81		22d. PHYSICIAN'S NAME (USE PRINT) W. W. CHAMBERS, M.D.		22e. ADDRESS 13018 Georgia Ave. Washington, Md 20006		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE Jan. 19, 1981		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. Silver Spring, Md.	
25a. DATE RECORDED BY REGISTRAR JAN 19 1981		25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]		25d. REGISTRAR'S ADDRESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

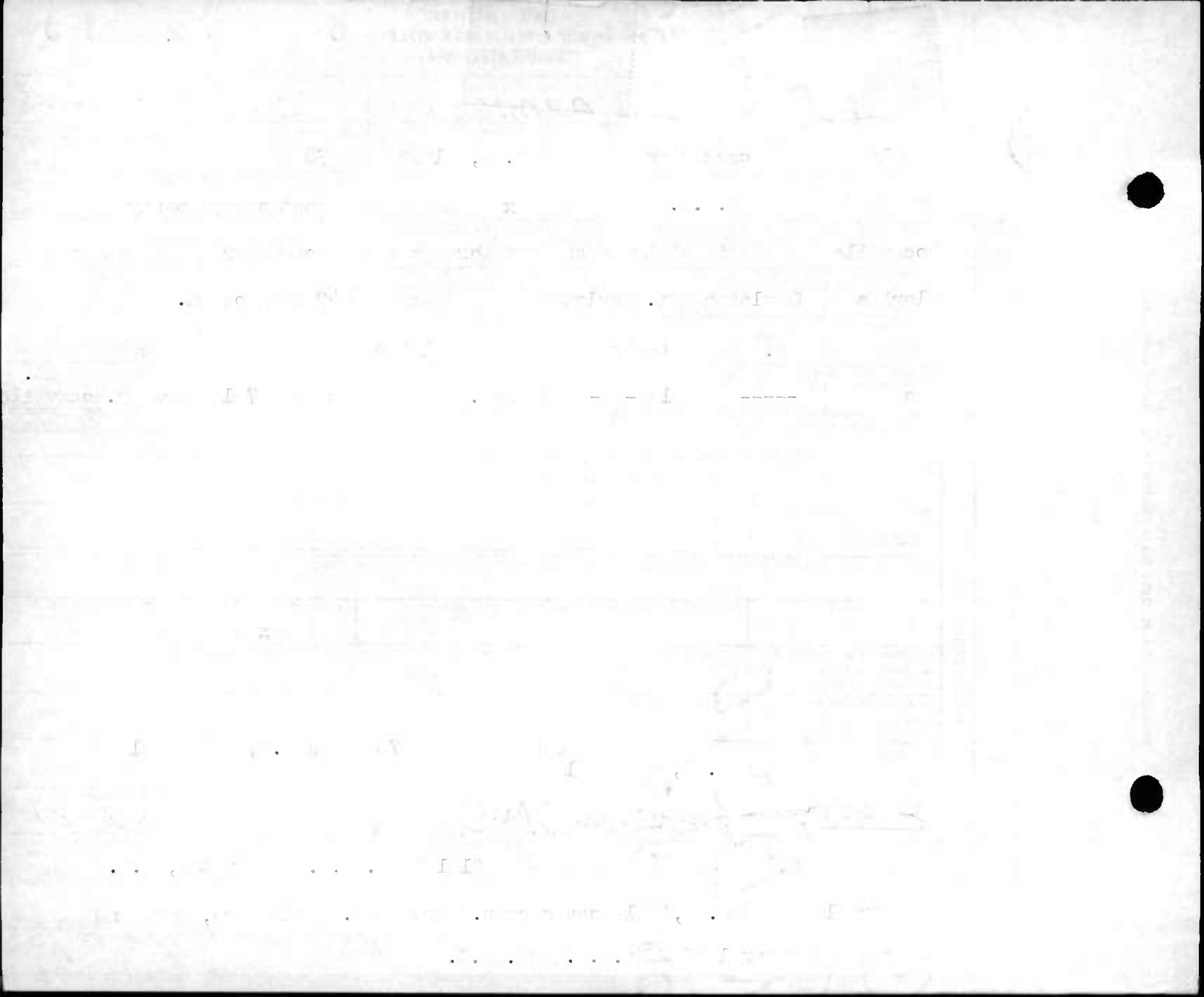
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR		REG. NO. 02330							
1. DECEASED NAME (TYPE OR PRINT) EDITH L. ARMIGER					2a. DATE OF DEATH MONTH DAY YEAR JAN-3-81			2b. HOUR 10:35 P M	
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1882		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home for the Aged				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY at home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Florida 13b. COUNTY Charlotte 13c. CITY OR TOWN Pt. Charlotte					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 849 Ivanhoe St.		
14. FATHER'S NAME FIRST MIDDLE LAST Frank S. Lewis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide Schad				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 139-54-4563		17. INFORMANT ADDRESS Rev. Richard Reichard 9701 Veirs Dr. Rockville Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June , 19 76 , to Jan. 3 , 19 81 , that (I) (we) lost saw the deceased alive on Jan. 3 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Elliott Aleskow, MD DEGREE MD						22c. DATE SIGNED 1-3-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT ALESKOW, MD						22e. ADDRESS 2141 K St. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 8, 1981		23c. NAME OF CEMETERY OR CREMATORY Govana Pres. Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR The Hysong Company 1300 N St. N.W. Wash. D.C.						25a. DATE REG'D BY REGISTRAR JAN 14 1981		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 2 3 3 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick Clarence Ash				2a. DATE OF DEATH MONTH DAY YEAR 1 12 81			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) foreman		12b. KIND OF BUSINESS OR INDUSTRY Chandalier	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. STREET ADDRESS 261 Congressional Apt. 710	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Henry Ash				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Lavina Duval			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 487-09-8821		17. INFORMANT ADDRESS F.E. Ash 11922 Stonewood Lane Rockville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (b) Phlebotrombosis, rt. leg DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease; mitral valve prolapse						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Chronic obstructive pulmonary disease; mitral valve prolapse							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Nov. 6, 1980 to Jan 12, 1981 , that (1) (we) saw the deceased alive on Jan 11, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE Sidney J. Cohen				DEGREE M.D.		22c. DATE SIGNED 1/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, M.D.				22e. ADDRESS 121 Congressional Lane, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/16/81		23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kansas City, Missouri	
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR JAN 10 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

1951 Rockville Pike, Rockville, Md. 20852
 Tyson Wheeler Funeral Home, Inc.
 Mt. Washington Cemetery, Kansas City, Missouri

1/16/81

Burial

no

--

Thomas

Henry

Ash

Martha

Irving

Duval

Rockville

X

261 Congressional Apt. 710

Maryland

Montgomery

Suburban Hospital

foreman

Chandler

Bethesda

USA

Arkansas

white

Male

Oct. 11, 1891

89

X

Frederick Clarence Ash

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marie K. Avedissian</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 10-81</i>		2b. HOUR HRS MIN <i>8 10 P.M.</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 1, 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HRS MIN <i>83</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Syria</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10. CITY OR TOWN OF DEATH <i>Kensington</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Kensington Gardens N.H.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Maryland Mont. Silver Spring</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>14200 Grand Pre Rd. Northgate Apts. Wheaton, Md.</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Kevin Yaghsejian</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Farida Yaghjian</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578 68 6379</i>		17. INFORMANT ADDRESS <i>Papken Pakhchanian 2027 Franwall Ave S.S. Md. 20902</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes, CHF, Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION <i>1-10-81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CHF</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>11-3</i> 19 <i>77</i> , to <i>1/10</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/10</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Frauke Westphal M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/10/1981</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frauke Westphal, M.D.</i>		22e. ADDRESS <i>809 Veirs Mill Rd. Rockville, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 13, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring, Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>W.W. Taltavull 4748 Wisc. Ave. N.W. Wash. D.C. 20016</i>				
25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>				

cleared with Medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 2 3 3 3	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Cecil L. Baker</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>1-20-81</i>		2b. HOUR <i>1005 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4-6-08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Painter Self-employed</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2 Burgundy Court</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Julius L. Baker</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cora Russ</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II</i>		17. INFORMANT ADDRESS <i>Wheaton, MD</i> <i>Lionel Baker 12110 Selfridge Road</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4275</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brain Damage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>G.D. Bleeding</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-14</i> 19 <i>81</i> , to <i>1-20</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1-20</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Gavin L. Flynn</i>						DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1-21/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GAVIN L. FLYNN</i>						22e. ADDRESS <i>9901 Medical Cntr Dr. Rockville MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Jan. 23, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Mem. Park</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> <i>Homes, P.A. Bethesda, Maryland</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

29

0903 BP

NOV 19 1944

RECEIVED

UNITED STATES DEPARTMENT OF THE INTERIOR

WASH DC

NOV 19 1944

RECEIVED

NOV 19 1944

UNITED STATES DEPARTMENT OF THE INTERIOR

RECEIVED

NOV 19 1944

RECEIVED

RECEIVED

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

UNITED STATES DEPARTMENT OF THE INTERIOR

UNITED STATES DEPARTMENT OF THE INTERIOR

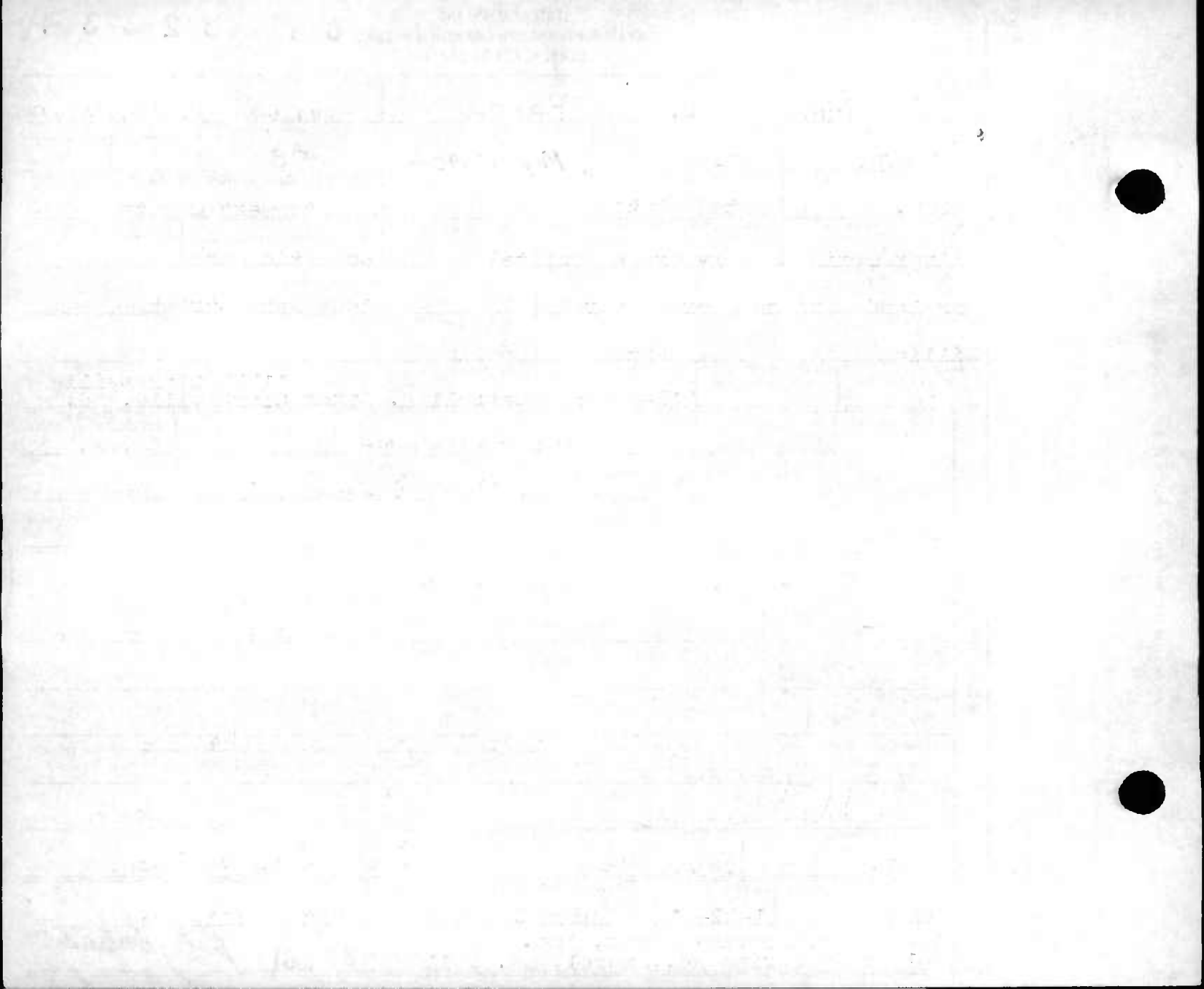
UNITED STATES DEPARTMENT OF THE INTERIOR

UNITED STATES DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 2 3 3 4	
1. STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MARY D. MIDDLE BAKER LAST				MONTH JANUARY DAY 19 YEAR 1981	
3. SEX FEMALE				2b. HOUR 0624PM	
4. RACE White				6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
5. DATE OF BIRTH MONTH MAY DAY 27 YEAR 1902				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.				7b. CITIZEN OF WHAT COUNTRY? United States	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH n Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic Work				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Prince George's	
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1008 Ward Street					
14. FATHER'S NAME FIRST William MIDDLE Martin LAST				15. MOTHER'S MAIDEN NAME FIRST Odelia MIDDLE Day LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-38-3506	
17. INFORMANT				ADDRESS 11772 Clarksville	
				Carroll R. Baker Clarksville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIAC ARRHYTHMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MIN.	
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE				YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) UREMIA - CHRONIC RENAL FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/19, 19 81, to 1/19, 19 81, that (I) (we) last saw the deceased alive on 1/19, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature] MD				22c. DATE SIGNED 1/20/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. Levy M.D.				22e. ADDRESS 1106 SPRING ST SILVER SPRING, MD 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-81		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE Md.	
24. FUNERAL DIRECTOR Flock Laurel Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Md. 20810				25. DATE REC'D. BY REGISTRAR 10 JAN 23 1981	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 3 5

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Kerna (NMN) Bardes			2a. DATE OF DEATH MONTH DAY YEAR January 16, 1981		2b. HOUR 4:55 pm		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 1, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery county MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth. Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer		12b. KIND OF BUSINESS OR INDUSTRY Gift Shop	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2601 Madison Ave. #1201		14. FATHER'S NAME FIRST MIDDLE LAST John H. Bardes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Avril P. Jowers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 009-52-1320		17. INFORMANT ADDRESS Mrs. Avril P. Bardes (mother) Warren, Vt.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7 4860 IMMEDIATE CAUSE (a) DIFFUSE, SEVERE PNEUMONITIS WITH DUE TO, OR AS A CONSEQUENCE OF PULMONARY HEPATIZATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVE S/P CHEMOTHERAPY FOR BURKITT'S LYMPHOMA, S/P OPEN LUNG BIOPSY POSITIVE FOR PNEUMOCYSTIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from January 7, 1981, to January 16, 1981, that (we) last saw the deceased alive on January 16, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.		22b. SIGNATURE Eric Sariban DEGREE	
22c. DATE SIGNED 01/17/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) SARIBAN, Eric		22e. ADDRESS National Institutes Of Health Clinical Center, Bethesda, Md 20205		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 18, 81		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		24b. DATE RECD. BY REGISTRAR JAN 22 1981		24c. REGISTRAR'S SIGNATURE		24d. ADDRESS 11800 New Hampshire Ave. Silver Spring, Md. 20910	

(173)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 3 6

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Albert W. BARTFELD			2a. DATE OF DEATH MONTH 1 DAY 29 YEAR 81			2b. HOUR 5:30 PM					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 3 DAY 4 YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ART DEALER		12b. KIND OF BUSINESS OR INDUSTRY ART			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN BETHESDA											
14. FATHER'S NAME FIRST HERMAN MIDDLE BARTFELD LAST BARTFELD				15. MOTHER'S MAIDEN NAME FIRST ROSA MIDDLE BEILER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 085-18-9931A		17. INFORMANT ADDRESS 6530 E. HALBERT ROAD, BETHESDA, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 2 days years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR AM MONTH 1 DAY 19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 15 , 19 81 , to Jan 29 , 19 81 , that (we) last saw the deceased alive on Jan 29 , 19 81 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
22b. SIGNATURE James Wagon				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/29/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES WEGAN				22e. ADDRESS 5413 Cedar Ln. - Bethesda Md 20014							
23a. BURIAL, CREMATION, REMOVAL (BURIAL)				23b. DATE 2/1/1981		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN				23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.											
25a. DATE REC'D. BY REGISTRAR FEB 4 1981 25b. REGISTRAR'S SIGNATURE [Signature]											

MEDICAL CERTIFICATION

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items #3x6 Film G559 9/3/81 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANITA E BAUGHARD			2a. DATE OF DEATH MONTH DAY YEAR 1/15/81		2b. HOUR 11:30 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5-24-19		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN DICKERSON				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2 Box 24301	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORA LITTLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 216 80 0884 17. INFORMANT ADDRESS J. Dee Baughard Dickerson Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic heart syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-6 hr 5-6 yr 6-10 yr.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/16 19 81 , to 1/16 19 81 , that (I) (we) lost saw the deceased alive on 1/16 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ruben C. Cosca, M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/16/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN C. COSCA, M.D.				22e. ADDRESS 1729 ARDEN RD. WOODBURY, MD 21780			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/19/81		23c. NAME OF CEMETERY OR CREMATORY SIMMONS		23d. LOCATION CITY OR TOWN COUNTY STATE ELIZABETH CATER TENN.	
24. FUNERAL DIRECTOR NAME Wickel ADDRESS Barnwell Rd.				25a. DATE REC'D. BY REGISTRAR JAN 26 1981		25b. REGISTRAR'S SIGNATURE Robert McCreary	



Amesbury, Mass. 1881
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Yours truly,
J. H. [Signature]

11/18/81

Received of [Name] the sum of [Amount] for [Purpose]

Very respectfully,
J. H. [Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02338																													
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. DATE ESTIMATED										2c. DATE PRONOUNCED DEAD																													
Antonio Josa Bayonet										1 MONTH 13 DAY 1981										1 MONTH 13 DAY 1981										1 MONTH 13 DAY 1981																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										7. IF UNDER 24 HRS.									
Male																				June 19, 1956										24 YRS.										MONTHS DAYS HOURS MIN										MONTH DAY YEAR									
7a. BIRTHPLACE (STATE OR COUNTY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																													
Santo Domingo										USA										NEVER MARRIED										Montgomery County, MD.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK)										12b. KIND OF BUSINESS																													
Takoma Park										Washington Adventist Hospital										Desk Clerk										Hotel																													
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																			
Maryland										Pr. Geo's										Hyattsville										YES										2606 Kirkwood Place																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT																			
Fausto Bayonet										Anna Ramirez										No										577-76-3355										Minerva Castro (sister) Cottage City, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																													
PART I DEATH WAS CAUSED BY:										21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED																													
IMMEDIATE CAUSE (a) Multiple Visceral and Skeletal Injuries										UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										1:21xx 1 13 1981										Driver of auto/fixed object impact																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION																													
										WHILE AT WORK										street										New Hampshire Ave. & Erskine Ave. Montgomery, Md.																													
22a. I certify that I took charge of the remains described above, held an										22b. I certify that I took charge of the remains described above, held an										22c. I certify that I took charge of the remains described above, held an										22d. I certify that I took charge of the remains described above, held an																													
death resulted from:										Autopsy										Inspection										Inquiry																													
Natural causes										Accident										Suicide										Homicide																													
Actual Signature										TITLE (SPECIFY)										DATE SIGNED										1/13/81																													
EXAMINER'S NAME										ADDRESS										111 Penn Street																																							
Virginia L. Dolan, M.D.																																																											
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																													
Removal										1/19/81										Cristo Redentor Cem										Santo Domingo, Dominican Rep																													
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Francis Gasch's Sons PA Hyattsville, Md.										JAN 16 1981																																																	

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

AS = 1, heads

conf. term:

low level

also see if 13 = all the other 13

also see 13 = 13

also see 13 = 13

also see (13 = 13) = 13

also see 13 = 13

also see 13 = 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB BELENKY			2a. DATE OF DEATH MONTH DAY YEAR January 23, 1981		2b. HOUR 10:45a M								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV 23 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. UNDER 1 YEAR MONTHS DAYS YRS.		7. UNDER 24 HRS HOURS MIN. YRS.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Willard Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN		12b. KIND OF BUSINESS OR INDUSTRY MEDICINE					
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS 4701 Willard Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID --- BELENKY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TAMARA --- HOLMSTOCK										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 119-36-4344			17. INFORMANT ADDRESS Adele Belenky; 4701 Willard Ave., ChCh Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 RECURRENT Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized cerebral vasculature 10 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Senility - EMACIATION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Senility - EMACIATION													
19a. DATE OF OPERATION -----			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR --- PM --- 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -----							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> -----			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -----			21f. LOCATION STREET CITY OR TOWN COUNTY STATE -----							
22a. I certify that (I) (this hospital) attended the deceased from 1-9 19 81 , to 1-23 19 81 , that (I) (we) last saw the deceased alive on 1-8 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Herbert L. Tanenbaum DEGREE MD						22c. DATE SIGNED 1-22-81			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT L. TANENBAUM, M.D.						22e. ADDRESS 5480 Wisconsin Avenue NW, Wash., D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 1-24-81		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND WASHINGTON D.C.						
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM CHAP ADDRESS MD. ROCKVILLE						25a. DATE RECEIVED BY REGISTRAR JAN 28 1981 25b. REGISTRAR'S SIGNATURE [Signature]							

0 2 2 0

THE UNIVERSITY OF CHICAGO
LIBRARY

(M)



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 4 0

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MORRIS BELLIN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 8 81</i>		2b. HOUR M <i>5 P</i>	
3 SEX <i>M ALE</i>		4 RACE <i>W HITE</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>12 5 03</i>		
6 AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY COUNTY MD.</i>				
10 CITY OR TOWN OF DEATH <i>CHEVY CHASE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CHEVY CHASE NURSING HOME</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SALESMAN</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>MEN'S CLOTHING</i>		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13b. STREET ADDRESS <i>1000 N.E. 14TH AVE.</i>		13c. CITY OR TOWN <i>HALLANDALE</i>				
13d. STATE <i>FLORIDA</i>		13e. COUNTY <i>✓</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>HARRY</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ALICE UNKNOWN</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>225-34-0443</i>		17 INFORMANT <i>MR. MURRAY BELLIN</i>		
		2709 VILLAGE LANE, SILVER SPRING, MD 20906				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>1659</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchogenic Carcinoma w/ht</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastasis to brain</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. <i>19</i>				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 19 80</i> to <i>Jan 8 81</i> , that (I) (we) last saw the deceased alive on <i>12/25/80</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>John Merendino</i>		DEGREE		22c. DATE SIGNED <i>JAN 8/81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN MERENDINO</i>		22e. ADDRESS <i>CHEVY CHASE NURSING HOME, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>JAN. 9, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW YOUNG MEN</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>		24 FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i> <i>601 O REISTERSTOWN RD. BALTO., MD 21215</i>				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Rifky Malbury</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Charles Grant

Bartholomew Grant with

W. T. Grant to him

18 8 81

The

18 8 81

Bartholomew

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

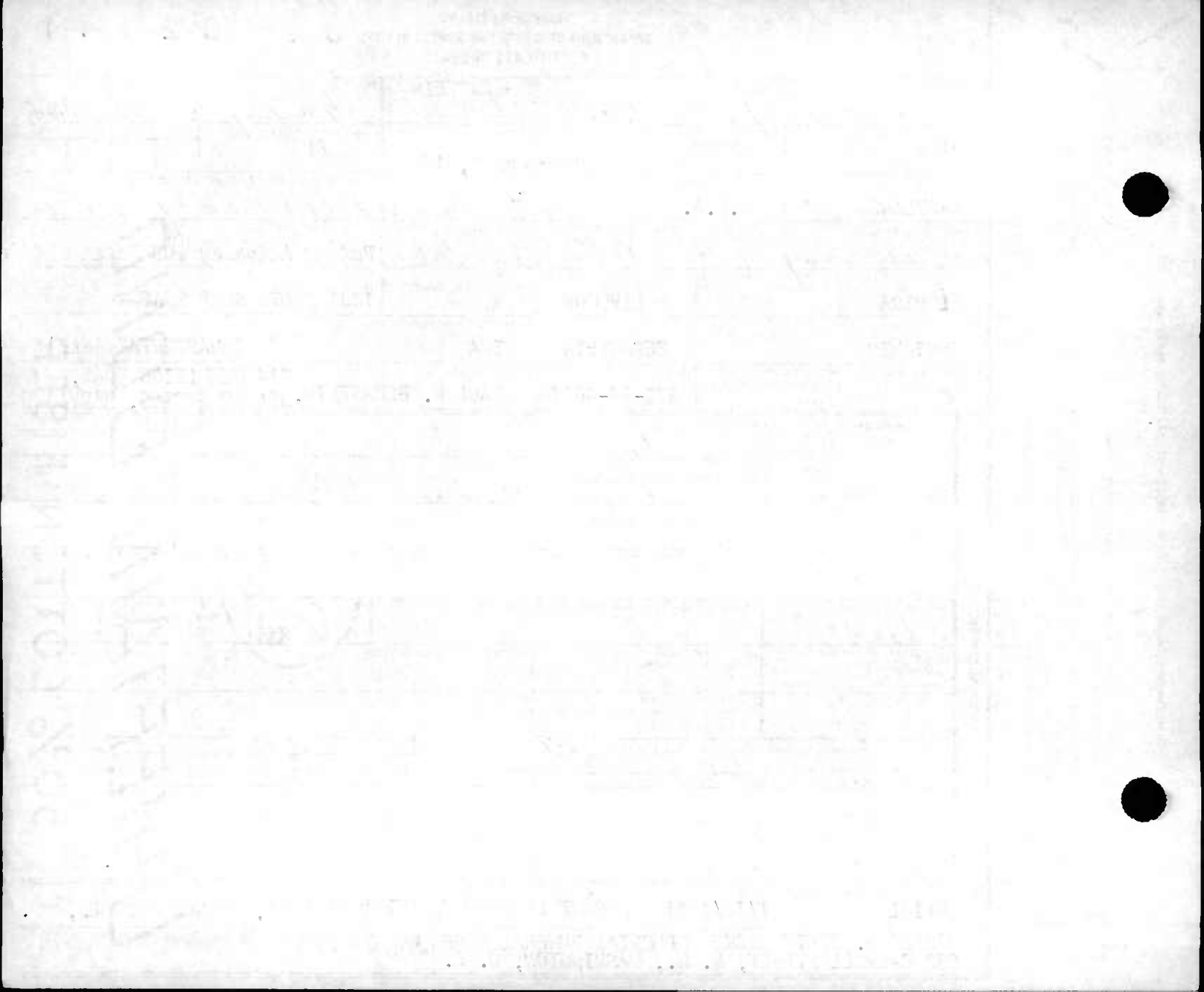
BP

DHMH-16 30M 2/80
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>SAMUEL</u> MIDDLE <u>BARNSTEIN</u> LAST <u>BERNSTEIN</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>January 16, 1981</u>		2b. HOUR <u>5:40 AM</u>	
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>November 7, 1899</u>	
6. AGE (IN YEARS, LAST BIRTHDAY) <u>81</u> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		9b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Not a Cross Hospital</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY County MD.</u>	
12a. USUAL RESIDENCE (IF HAVING HOME IN OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>FLORIDA</u>		13b. CITY OR TOWN <u>HOLLYWOOD</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>BENJAMIN</u> <u>BERNSTEIN</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>IDA</u> <u>(UNASCERTAINABLE)</u>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Patent Attorney</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579-54-6038M</u>		17. INFORMANT ADDRESS <u>714 HERMLEIGH ROAD, SILVER SPRING, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Seizure Disorder</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <u>NONE</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>80</u> , to <u>1/15</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/15</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>1/16/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joel Schulman</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <u>7410 21st Georgetown Rd Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>1/18/1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT LEBANON CEMETERY</u>	
23d. LOCATION <u>ADELPHI, PRINCE GEORGES, MD.</u>		23e. DATE RECD. BY REGISTRAR <u>JAN 20 1981</u>		23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR NAME <u>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</u> <u>232 CARROLL STREET, N. W., WASHINGTON, D. C.</u>					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 4 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE		LAST BIRCH		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH		MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		17b. KIND OF BUSINESS OR INDUSTRY HOME			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		17b. KIND OF BUSINESS OR INDUSTRY HOME		13a. STATE MD		13b. COUNTY MONTG.		13c. CITY OR TOWN SIL. SPR.	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS -- REICHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST -- -- REICHER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 099-10-4695		17. INFORMANT ADDRESS NORMAN PERLSON 1131 UNIV. BLVD S.S. MD.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20902 1131 UNIVERSITY BLVD-W	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>1533</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic adenocarcinoma to lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sigmoid adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>3 years</u>		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerotic Heart Disease</u>		19a. DATE OF OPERATION -----		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -----		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -----		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -----			
22a. I certify that (1) (this hospital) attended the deceased from <u>SEPT 79</u> to <u>JAN 81</u> , that (1) (we) lost saw the deceased alive on <u>JAN 4</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did/did not) view the body after death.		22b. SIGNATURE <u>Robert L. Rosenberg</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED -----					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, M.D.		22e. ADDRESS 1131 UNIVERSITY BLVD. W, SILVER SPRING, MD.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-8-81		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON, N.Y.		23d. LOCATION CITY OR TOWN COUNTY STATE N.Y.			
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PK. ROCKVILLE, MD.		25a. DATE REC'D. BY REGISTRAR JAN 12 1981		25b. REGISTRAR'S SIGNATURE <u>Angela</u>									

1950 12 27 1950 12 27 1950 12 27

1950 12 27 1950 12 27 1950 12 27

1950 12 27 1950 12 27 1950 12 27

1950 12 27 1950 12 27 1950 12 27

1950 12 27 1950 12 27 1950 12 27

1950 12 27 1950 12 27 1950 12 27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1- FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR				
FIRST MIDDLE LAST					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR				
HOWARD E. BLACK					JANUARY 2 1981				9 ¹⁰ AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		March 22, 1896		84		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Georgia		U.S.A.				Montgomery				MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chevy Chase		Beth. Retirement Ctr.				Asst. Clerk ;US		Supreme Court					
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland					Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8700 Jones Mill Road		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST					FIRST MIDDLE LAST								
Earl -- Black					Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
Yes					WW I		215-46-2712					Clayton N. Conger, 2000 Huntington Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Coronary heart failure</i>													
4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			HOUR A.M. MONTH DAY YEAR										
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN COUNTY STATE				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET							
22a. I certify that (I) was <i>did</i> attend the deceased from <i>Dec 28</i> , 19 <i>80</i> , to <i>Jan 3</i> , 19 <i>81</i> , that (I) we <i>we</i> lost saw the deceased alive on <i>Dec 28</i> , 19 <i>80</i> , and that in (my) our <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) we <i>we</i> did not <i>view</i> the body after death.													
22b. SIGNATURE						DEGREE			22c. DATE SIGNED				
<i>Jack Kleh</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			1/2/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Jack Kleh, M.D.						1145 - 19th St. N.W. Wash., D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION					
Burial			1/7/81		Cedar Hill Cemetery			Suitland, Maryland					
24. FUNERAL DIRECTOR						25. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE				
NAME ADDRESS						JAN 12 1981			<i>John H. H. H.</i>				
5130 Wisconsin Ave., NW, Washington, D.C. 20016													



JANUARY 2 1961

84

March 22, 1960

White

Male

X

U.S.A.

Georgia

East. 1011; 15 in some count

See 112 and 113

X

Heavy Green

Antennary

Analysis

Unknown

Leaf

--

Leaf

Examination, Virginia
County, 5000

Director, 5000

511-44-115

W I

Yes

Virginia, Maryland

County, 5000

W I

Analysis

John H. Hester, Inc.

511-44-115, 5000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
 1- STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William R Black			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Jan 29 1981			2b. HOUR 2:45 M PM		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct-3 16 64	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 16	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Jan 29 1981		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Blney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY Metro System
13a. STATE MD.		13b. COUNTY Mont	13c. CITY OR TOWN Silver Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3912 P2/mirz Lane		
14. FATHER'S NAME FIRST MIDDLE LAST Jason Black		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Heflin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII				
16b. SOCIAL SECURITY NO. 577-40-7032		17. INFORMANT Sarah C. Black (Same as 13e)					ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8880 Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Fall DUE TO, OR AS A CONSEQUENCE OF (c) Drinking APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days 18 days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic Liver Disease								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1100 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall at home				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Palmira Lane Silver Spg Monte Md				
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				TITLE (SPECIFY) Dep				
ACTUAL SIGNATURE John S. Rogers		M.D. Dep			MEDICAL EXAMINER		DATE SIGNED Jan 29 1981	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Silver Spring, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Feb. 2, 1981		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 5 1981		25b. REGISTRAR'S SIGNATURE [Signature]		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100-100000
100-100000
100-100000

100-100000
100-100000
100-100000

100-100000
100-100000

100-100000
100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

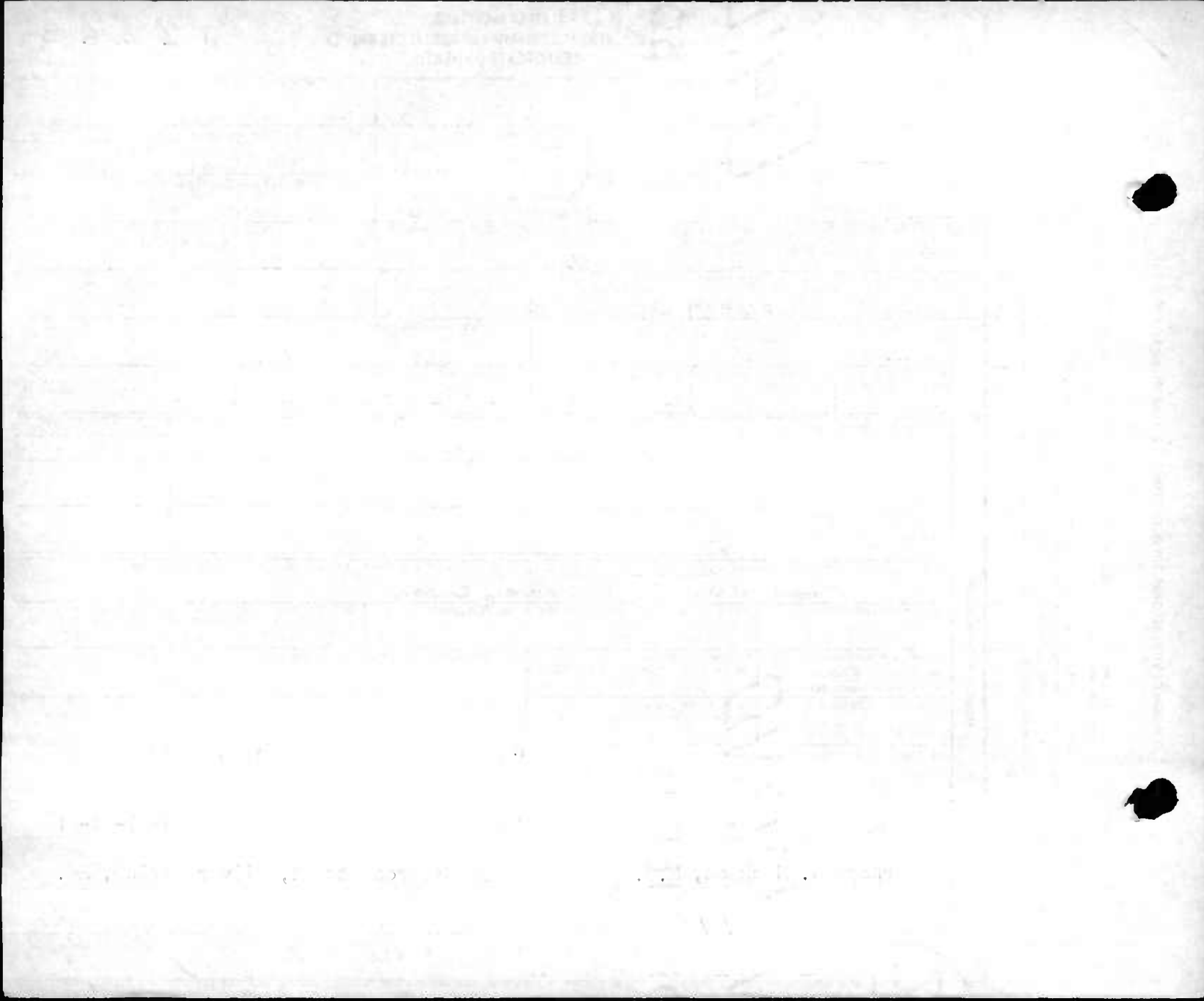
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES ANDREW BLAKE			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1981		2b. HOUR 5:15P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 3 1896		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		10. CITY OR TOWN OF DEATH Silver Spring		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2802 Terrapin Road 20906				
14. FATHER'S NAME FIRST MIDDLE LAST Poulter C. Blake		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie C. Faulkner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 230-09-3923		17. INFORMANT ADDRESS Kathy Lizear 2802 Terrapin Rd. Silver Sprg. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ampylary Carcinoma</u> 1562 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Obstructive Pulmonary Disease</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>80</u> , to <u>1/29</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/29</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Bernard A. Heckman,</u>		DEGREE M.D.		22c. DATE SIGNED 1-30-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard A. Heckman, M.D.		22e. ADDRESS 8830 Cameron Street, Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/81		23c. NAME OF CEMETERY OR CREMATORY Fairfax Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va. Fairfax Virginia		24. FUNERAL DIRECTOR NAME ADDRESS Murphy Funeral Home 1102 W. Broad St.				



FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 4 6

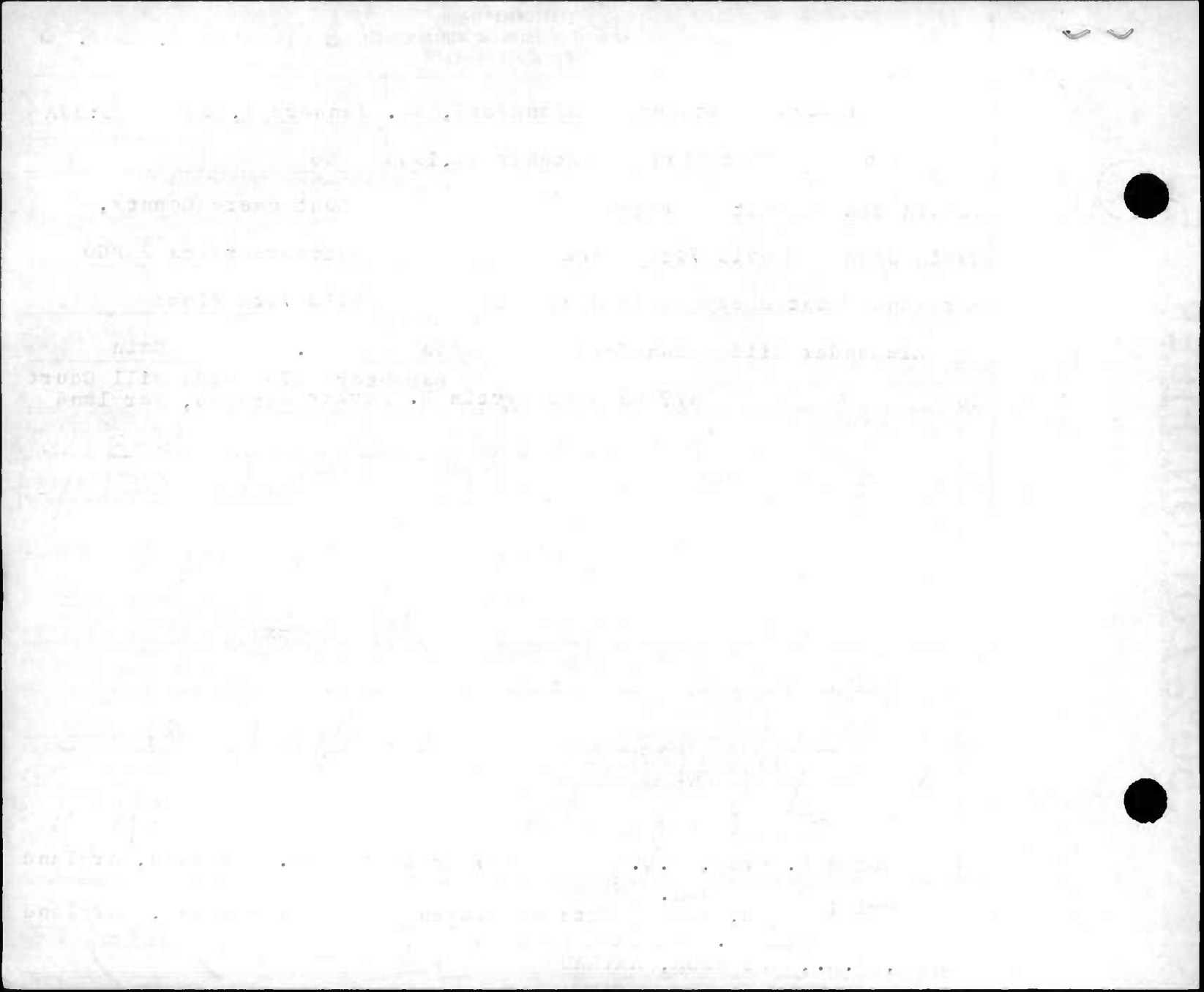
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Anthony Blandford, SR.			2a. DATE OF DEATH MONTH DAY YEAR January 1, 1981		2b. HOUR 3:30 AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 18, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Cabin John		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6513 79th Place			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Customer Service		12b. KIND OF BUSINESS OR INDUSTRY PEPCO		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Hill Blandford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Cain					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 05 0563		17. INFORMANT ADDRESS Daughter 6700 Olde Mill Court Myrtle B. Parker Derwood, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 Respiratory failure IMMEDIATE CAUSE (a) DUE TO OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO OR AS A CONSEQUENCE OF (c) Mass. vt. upper lung cyst, Etiology unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 20+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 12/29/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mass. vt. upper lung cyst, Etiology unknown			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6513 79th Place Cabin John Montgomery Maryland					
22a. I certify that (I) (the hospital) attended the deceased from 12/29/80 to 1/1/81 , that (I) was last saw the deceased alive on 12/29/80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George A. Gray, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/1/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George A. Gray, M.D.				22e. ADDRESS 6917 Arlington Rd. Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 3, 1981		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR JAN 5 1981					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Item 6 g553 3/10/81 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 !

0 2 3 4 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther F. Bloomer			2r. DATE OF DEATH MONTH DAY YEAR 1-25-81		2b. HOUR 1138 PM		
3 SEX female		4 RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 4-8-1893		6. AGE [IN YEARS LAST BIRTHDAY] 87 88 YRS # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Media, PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen M. Foote				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah -- Brooke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS George B. Bloomer, Jr., Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days Many Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that at ^{on} (this hospital) attended the deceased from Feb 19 78 to Jan 25 19 81 , that we (we) lost saw the deceased alive on 1/25/81 19 --- and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we ^{we} did not view the body after death.)							
22b. SIGNATURE James W. Egan				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/26/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN				22e. ADDRESS 5413 Cedar Ln - 206c Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/29/81		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				25. DATE REC'D. BY REGISTRAR JAN 30 1981			
25b. REGISTRAR'S SIGNATURE Joseph Gawler's Sons, Inc.				25c. REGISTRAR'S SIGNATURE Joseph Gawler's Sons, Inc.			

515 Wisconsin Ave., N.W., Washington, D.C.
 Boston Office: 100 State St., Boston, Mass.
 1/25/61
 Mr. Tolson

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 4 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE MILDRED BLOSSER			2a. DATE OF DEATH MONTH DAY YEAR 1 1 81		2b. HOUR MIN. 5:15 A
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 3 31 22		6. AGE (IN YEARS LAST BIRTHDAY) 58	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADM. AD.	12b. KIND OF BUSINESS OR INDUSTRY NATL GEOGRAPHIC	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN KENSINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3804 DECATUR AVENUE
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES GRIFFIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN KEIFER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 193-16-5351		17. INFORMANT ADDRESS ROBERT E. BLOSSER, SR. SAME AS 13 HUSBAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIFFUSE HISTIOCYTIC LYMPHOMA 2000 } DUE TO, OR AS A CONSEQUENCE OF WITH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) LIPPER GI HEMORRHAGE DUE TO DUE TO, OR AS A CONSEQUENCE OF GASTRIC LYMPHOMA (c) 1 WK					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (we) hospital attended the deceased from JUNE 19 79 to DEC 31 19 80 , that (we) (we) last saw the deceased alive on DEC 31 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (did not) view the body after death.					
22b. SIGNATURE James G. Brown, MD		DEGREE		22c. DATE SIGNED 1/1/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD		22e. ADDRESS 6525 BELCREST RD HYATTSVILLE MD 20782			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/5/81	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR JAN 5 1981		
ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MARYLAND			25b. REGISTRAR'S SIGNATURE Robert E. Blosser, Sr.		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

332233

8

33 12 1

RECEIVED - 15 JAN 65

ADJUTANT GENERAL

WASHINGTON, D. C. 20315

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

15 JAN 65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUIS BLUMENTHAL			2a. DATE OF DEATH MONTH DAY YEAR 01/19/81		2b. HOUR 7:45 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 10, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY MENS CLOTHING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHEVY CHASE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME VELVEL		15. MOTHER'S MAIDEN NAME GITTEL		16. STREET ADDRESS 2632 COLSTON DRIVE	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		17b. SOCIAL SECURITY NO. 577-50-4507A		17c. INFORMANT ADDRESS GERALDINE SCHNITMAN, same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4279 CARDIAC ARRYTHMIA (PROBABLE) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DEMENTIA, PRESUMABLY SENILE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/16/80 to 1/19/81, that (I) (we) last saw the deceased alive on 1/19/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. D. Patel		DEGREE M.D.		22c. DATE SIGNED 1/19/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL		22e. ADDRESS 6121 MONTROSE RD, Rockville, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/20/1981		23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CONGREGATION HILLSIDE, PR. GEORGES, MD.	
23d. LOCATION CITY OR TOWN COUNTY STATE SARASOTA FL		23e. NAME OF FUNERAL HOME HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.			
24. FORMAL DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME					

MEDICAL CERTIFICATION

2700 BP

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

1981





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 3 5 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clitus O. Bourdeaux			2a. DATE OF DEATH MONTH DAY YEAR January 21, 1981		2b. HOUR 5:14p M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 21 1905		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Miss.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney	12b. KIND OF BUSINESS OR INDUSTRY Law
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Laytonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8510 Brink Rd.
14 FATHER'S NAME FIRST MIDDLE LAST Clitus Oliver Bourdeaux, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona - Ellis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 217-14-7230 A	17 INFORMANT ADDRESS 8510 Brink Rd., Gaithersburg, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ESOPHAGEAL CARCINOMA 1509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 15, 1981, to JAN 21, 1981, that (I) (we) last saw the deceased alive on JAN 21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eugene P. Flannery		DEGREE		22c. DATE SIGNED Jan 21, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY		22e. ADDRESS 18111 PRINCE PHILIP DR.-OLNEY, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 24, '81	23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montgomery, Md.
24 FUNERAL DIRECTOR Gartner Sandison F. H.		316 E. Diamond Ave.		25 REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 150.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8102351	
1. FOR STATE REGISTRAR Felix W. Bowen											
1. DECEASED NAME (TYPE OR PRINT) Felix W. BOWEN						2a. DATE OF DEATH MONTH DAY YEAR 1-3-81		2b. HOUR 9:23 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 12, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Barbados		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect		12b. KIND OF BUSINESS OR INDUSTRY Arch. Firm			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4803 Jamestown Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest F. Bowen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Wedgewood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 109-12-4064		17. INFORMANT ADDRESS Elsa E. Bowen Same as Item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery 2765 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration + Pre-renal Azotemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 h 72 h	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Mild to Moderate Cerebrovascular Accident											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 2 , 19 81 , to Jan 3 , 19 81 , that (I) (we) last saw the deceased alive on Jan 2 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William H. Killian DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/3/1981			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Killian						22e. ADDRESS 8218 Wisconsin Ave Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/6/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N. W. Wash., D.C.						25. DATE REC'D BY REGISTRAR JAN 12 1981		25b. REGISTRAR'S SIGNATURE Robert McCreedy			

John W. Bowen

John W. Bowen

John W. Bowen

John W. Bowen

John W. Bowen

John W. Bowen

John W. Bowen

John W. Bowen

John W. Bowen

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 5 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IRENE R. BRADY			2a. DATE OF DEATH MONTH DAY YEAR 1 8 81			2b. HOUR 6:15 P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 14 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALTHEA WOODLAND N.H. 1000 Daleview				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Keeper		12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7051 Takoma Towers Apt 610	
14. FATHER'S NAME FIRST MIDDLE LAST John BRADY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE Zimberlin			16. DR. Rosemarie Rogers niece Bethesda			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 165-07-7305		17. INFORMANT 4424 Rosedale Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20014									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS Anemia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 22 1980 to Jan 8 1981 , that (we) lost saw the deceased alive on Jan 8 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/8/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD			22e. ADDRESS 217 UNIVERSITY BLVD EAT SILVER SPRING MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE January 12 1981		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Humphrey			ADDRESS Homes, P.A. Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR JAN 14 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

SECRET

10

RECEIVED

SECRET

1984-10-10

SECRET

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 5 3

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE BRODSKY			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1981		2b. HOUR 12:07 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 30, 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS 0 0		7. UNDER 24 HRS HOURS MIN. 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			
11. CITY OR TOWN OF DEATH Chevy Chase			12. KIND OF BUSINESS OR INDUSTRY -----			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Sil. Spg.						
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Pogrobin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 107-36-9131		17. INFORMANT ADDRESS Philip Brodsky; P.O. Box 409, SSpg., Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 5 Years 15 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized cerebral arteriosclerosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 19 66		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the deceased) attended the deceased from June 10, 1966 , to January 31, 1981 , that (I) (we) last saw the deceased alive on Jan. 30, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Paul R. Wilner M.D.				22c. DATE SIGNED 1-31-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL R. WILNER, M.D.				22e. ADDRESS 2700 Calvert Street N.W., Wash., DC		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 2, 1981		23c. NAME OF CEMETERY OR CREMATORY Montefiore Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE St. Albans, New York		24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike Rockville, Md.				
25a. DATE REC'D. BY REGISTRAR FEB 6 1981		25b. REGISTRAR'S SIGNATURE				

0 2 2 0 1 8

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 5 4

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) XXXXXXXXXX JOHNNIE PEARL Bromley			2a. DATE OF DEATH MONTH DAY YEAR 1/7/81		2b. HOUR 1:30 AM	
3. SEX Female	4. RACE cauc.	5. DATE OF BIRTH MONTH DAY YEAR 9 14 04		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2932 MARLOW ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BAILEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA SHELTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-74-3327		17. INFORMANT ADDRESS KAY B. McMILLAN SAME AS 13 DAUGHTER		

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) C.O.R.D. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 0		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 0	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 0		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-10-80 19____, to 1-7-81 19____, that (I) (we) last saw the deceased alive on 1-6-81 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles L. Franklin Jr		DEGREE MD		22c. DATE SIGNED 1-7-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) il 200 Lockwood Silver Sp Md 20901 Charles L Franklin Jr		22e. ADDRESS POTOMAC MONT MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/9/81	23c. NAME OF CEMETERY OR CREMATORY POTOMAC UNITED METHODIST	23d. LOCATION CITY OR TOWN COUNTY STATE POTOMAC MONT MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR JAN 12 1981	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25b. REGISTRAR'S SIGNATURE John H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02355	
1. FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Hede Broner						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 1 12 19 81		2b. HOUR P			
3. SEX Fe		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 7 4 94		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 86		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 1 12 19 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10401 GRISWOLD PL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist		12b. KIND OF BUSINESS OR INDUSTRY Arts			
13a. STATE MD						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Theodor Schreus Maria						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Dressen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 119-18-7324A		17. INFORMANT ADDRESS Ruth Cahnmann; 5430 Beech Ave. Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 12 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND DEAD IN APT.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10401 GRISWOLD PL. BETHESDA MONT MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C. Mayle MD				TITLE (SPECIFY) Dept				MEDICAL EXAMINER		DATE SIGNED 1/13/81	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M. D.				ADDRESS 8200 Wisconsin Ave, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1-13-1981		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels;				ADDRESS 1170 Rockville Pike				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Proddy	

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

02.03

STANDARD OIL COMPANY
NEW EXAMINING CENTRAL

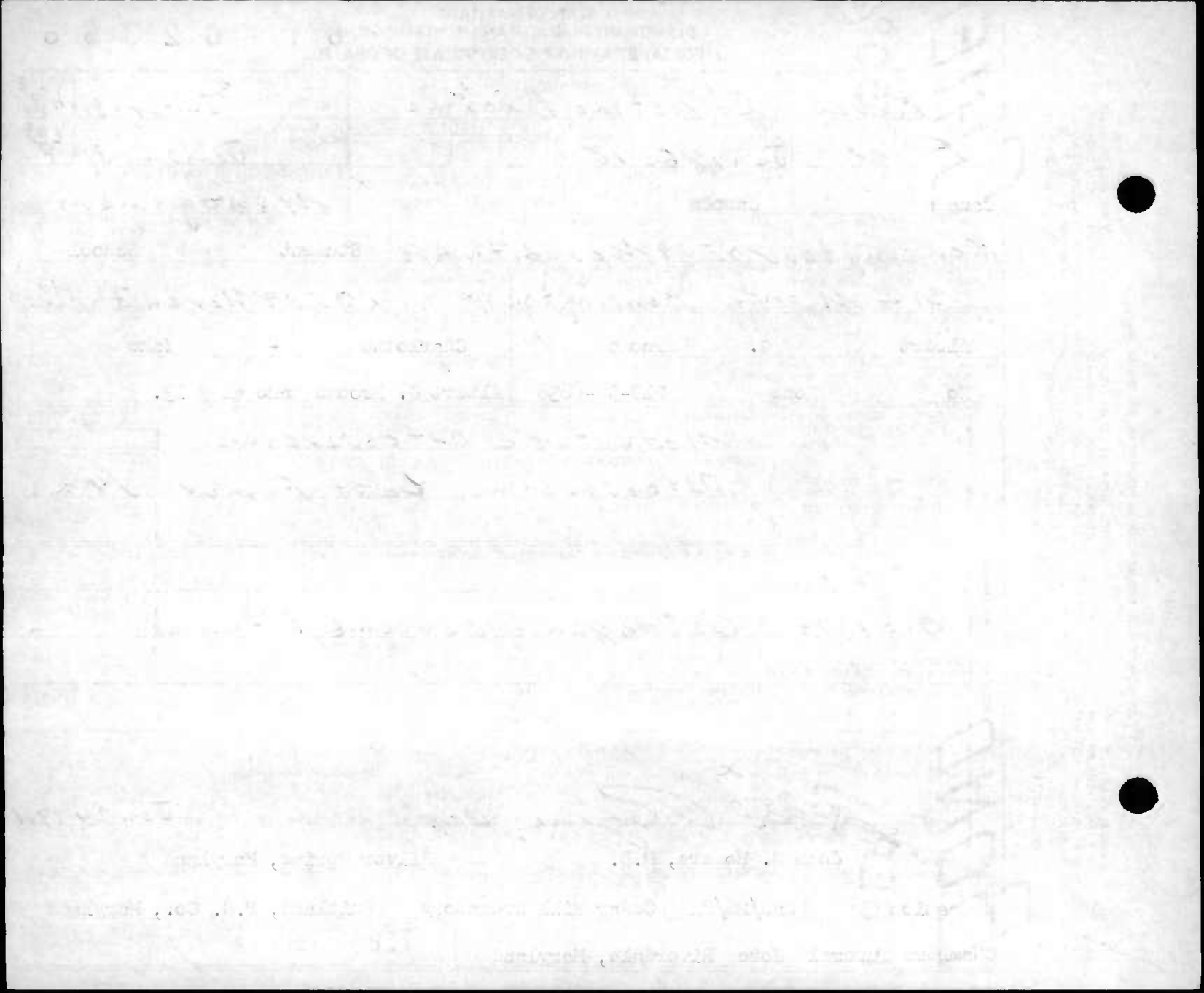
DATE		TIME		PLACE		REMARKS	
1911	10/1	10:00	11:00	1000	1000	1000	1000
1911	10/2	10:00	11:00	1000	1000	1000	1000
1911	10/3	10:00	11:00	1000	1000	1000	1000
1911	10/4	10:00	11:00	1000	1000	1000	1000
1911	10/5	10:00	11:00	1000	1000	1000	1000
1911	10/6	10:00	11:00	1000	1000	1000	1000
1911	10/7	10:00	11:00	1000	1000	1000	1000
1911	10/8	10:00	11:00	1000	1000	1000	1000
1911	10/9	10:00	11:00	1000	1000	1000	1000
1911	10/10	10:00	11:00	1000	1000	1000	1000
1911	10/11	10:00	11:00	1000	1000	1000	1000
1911	10/12	10:00	11:00	1000	1000	1000	1000
1911	10/13	10:00	11:00	1000	1000	1000	1000
1911	10/14	10:00	11:00	1000	1000	1000	1000
1911	10/15	10:00	11:00	1000	1000	1000	1000
1911	10/16	10:00	11:00	1000	1000	1000	1000
1911	10/17	10:00	11:00	1000	1000	1000	1000
1911	10/18	10:00	11:00	1000	1000	1000	1000
1911	10/19	10:00	11:00	1000	1000	1000	1000
1911	10/20	10:00	11:00	1000	1000	1000	1000
1911	10/21	10:00	11:00	1000	1000	1000	1000
1911	10/22	10:00	11:00	1000	1000	1000	1000
1911	10/23	10:00	11:00	1000	1000	1000	1000
1911	10/24	10:00	11:00	1000	1000	1000	1000
1911	10/25	10:00	11:00	1000	1000	1000	1000
1911	10/26	10:00	11:00	1000	1000	1000	1000
1911	10/27	10:00	11:00	1000	1000	1000	1000
1911	10/28	10:00	11:00	1000	1000	1000	1000
1911	10/29	10:00	11:00	1000	1000	1000	1000
1911	10/30	10:00	11:00	1000	1000	1000	1000
1911	10/31	10:00	11:00	1000	1000	1000	1000

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 2 3 5 6

1. DECEASED NAME (TYPE OR PRINT) <i>Karen Christine Broome</i>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>Jan 24 1981</i>			2b. HOUR OF DEATH M <i>6:00</i>		
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 18 1963</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>18</i> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Jan 24 1981</i>		2d. HOUR M <i>6:00</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Canada</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Canada</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD		
10. CITY OR TOWN OF DEATH <i>Kensington</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) <i>10509 Meredith Ave</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Student</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>School</i>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert G. Broome</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Charlotte - Yake</i>		13e. STREET ADDRESS <i>10509 Meredith Ave</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>None</i>		17. INFORMANT ADDRESS <i>Albert G. Broome Same as # 13.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>1991</i> IMMEDIATE CAUSE (a) <i>Metastatic Osteosarcoma.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Osteosarcoma, Left Femur</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>14 mo</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>								
19a. DATE OF OPERATION <i>Dec 1979</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Osteogenic sarcoma, l. femur</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i>		MEDICAL EXAMINER			DATE SIGNED <i>Jan 24 1981</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>		ADDRESS <i>Silver Spring, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Jan/26/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, P.G. Co., Maryland</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Chambers Funeral Home Riverdale, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony A. Crandall</i>		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 5 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET E Brown			2a. DATE OF DEATH MONTH DAY YEAR 1-3-81			2b. HOUR 1:30 A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb 28 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Unknown		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE D. C.			13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Parker			13e. STREET ADDRESS 600 Irving Street, N.W.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 579-09-0481		17. INFORMANT ADDRESS Mr. Roy N. Brown/husband/same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) (2) CVA DUE TO, OR AS A CONSEQUENCE OF (b) CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) CAD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): HBP ASCVD									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> None			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-24-80 , 19____, to 1-3-81 , 19____, that (I) (we) last saw the deceased alive on 12-2-80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE HBP Patrick MD			DEGREE			22c. DATE SIGNED 1-3-81			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick MD			22e. ADDRESS 9221 Coleville Rd Silver Spring, Md 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-8-81		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md		
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St., N.E., D. C.					25a. DATE REC'D. BY REGISTRAR JAN 12 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 281

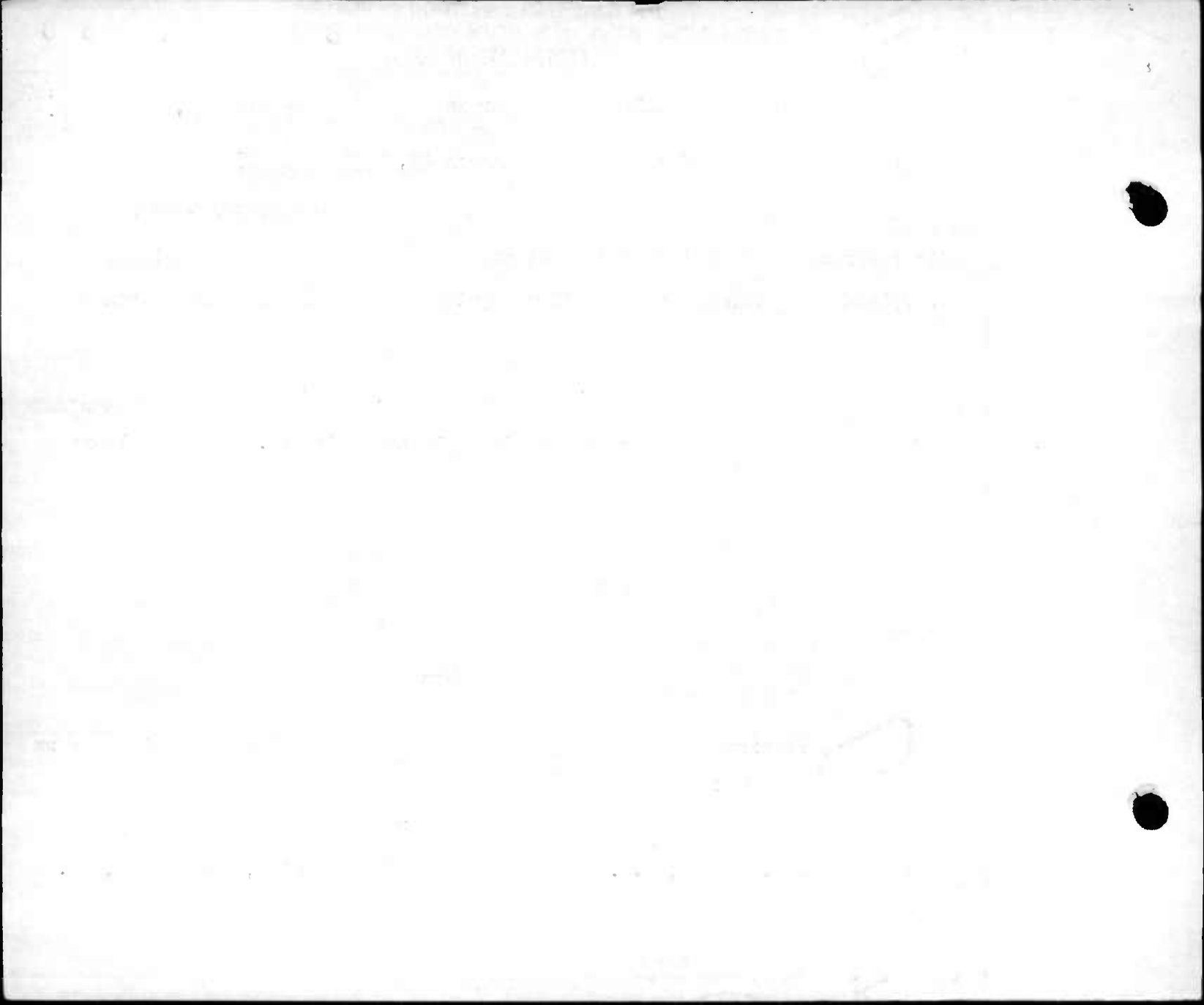
1292 J. RAO

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 **2 3 5 8**
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Robert Allen Brown			2a. DATE OF DEATH Month January Day 5 Year 1981		2b. HOUR 7:17 M A.
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 23, 1907		6. AGE (In years lost birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 604 Deerfield Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired	12b. KIND OF BUSINESS OR INDUSTRY Postal Serv.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 604 Deerfield Avenue
14. FATHER'S NAME First Philip Middle P. Last Brown		15. MOTHER'S MAIDEN NAME First Gertrude Middle Last Batt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT (wife) Address Marie B. Brown-(same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease. 4960 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (did not) attended the deceased from 1/18 , 19 66 , to 1/4 , 19 81 , that (I) (was) did saw the deceased alive on 1/4 , 19 81 , and that in (my) (best) own opinion death occurred on the date and hour and from the causes stated above, (I) (did) did not view the body after death.					
22b. SIGNATURE 		22c. DATE SIGNED 1/5/81		22d. PHYSICIAN'S NAME (Type) John S. Rogers, M.D.	
22e. ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-7-1981	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR JAN 13 1981		25b. REGISTRAR'S SIGNATURE 	
24. ADDRESS 8434 Ga. Ave., S.S. Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 5 9

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Virginia L. Brown</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1 4 81</i>				2b. HOUR <i>11:54 AM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 22 89</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i>		7. UNDER 1 YEAR MONTHS DAYS <i>YES</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>			
10. CITY OR TOWN OF DEATH <i>SILVER SPRING, MD.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>MONT</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1716 Tilton Drive,</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Hartig</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>(unknown)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>-0-</i>		17. INFORMANT <i>James Brown-son- Sil. Spring, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH <i>minutes</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I, this hospital) attended the deceased from <i>August</i> , 19 <i>76</i> , to <i>Jan. 4</i> , 19 <i>81</i> , that (we) lost saw the deceased alive on <i>Jan 1</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Milton J. Koch</i>				DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/4/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MILTON J. KOCH, M.D.</i>				22e. ADDRESS <i>2101 Medical Park Drive Silver Spring, MD. 20902</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-7-1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sil. Spring Montgomery Md.</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i> <i>8434 Ca. Ave., S.S. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 8 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #2a per phone call w/Fun. Home STATE OF MARYLAND
 1- STATE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 1 0 2 3 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Barbara Bryan			2a. DATE OF DEATH Jan. 29th 1981 1 28 81		2b. HOUR 8:30AM						
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 Chestnut St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland						13c. COUNTY Mont.		13d. CITY OR TOWN Gaithersburg		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Edward Burroughs						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Ursula Peter.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-18-2577		17. INFORMANT ADDRESS Elizabeth Mainhart Gaithersburg, Md. 20760							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>adipose tissue Cellulitis - Metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Week 6 Months 6 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>chronic heart failure</u> - <u>HED</u>											
19a. DATE OF OPERATION 12-24-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTestinal Obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>November 24</u> , 19 <u>75</u> , to <u>January 29</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>January 16</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/29/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGARIO BOIS				22e. ADDRESS 13 E DEER PARK DR. GAITHERSBURG							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 31, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clarksville Howard Md.					
24. FUNERAL DIRECTOR NAME Francis H. Barber Funeral Home Laytonsville Maryland 20760						25a. DATE REC'D. BY REGISTRAR FEB 2 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 6 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HUGH L. Buckingham			2a. DATE OF DEATH MONTH DAY YEAR 1 20 81			2b. HOUR 4:30 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6- 25 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, CITY, GIVE STREET ADDRESS) 9407 Hale Place		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY H.L. Rust, Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil. Spring							
14. FATHER'S NAME FIRST MIDDLE LAST William Buckingham		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Pope					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 578-07-1829		17. INFORMANT (wife) ADDRESS Margaret M. Buckingham-(same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>did not</u> attend the deceased from <u>1-18</u> 19 <u>81</u> , to <u>1-20</u> 19 <u>81</u> , that (I) <u>did</u> lose the deceased alive on <u>1-18</u> 19 <u>81</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> view the body after death.							
22b. SIGNATURE <u>G. Sengstack</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-20-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Sengstack, MD				22e. ADDRESS 9241 Columbia Blvd., S.S. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25. DATE OF DEATH BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Kath. W. [Signature]</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

PLANT INDUSTRY

PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

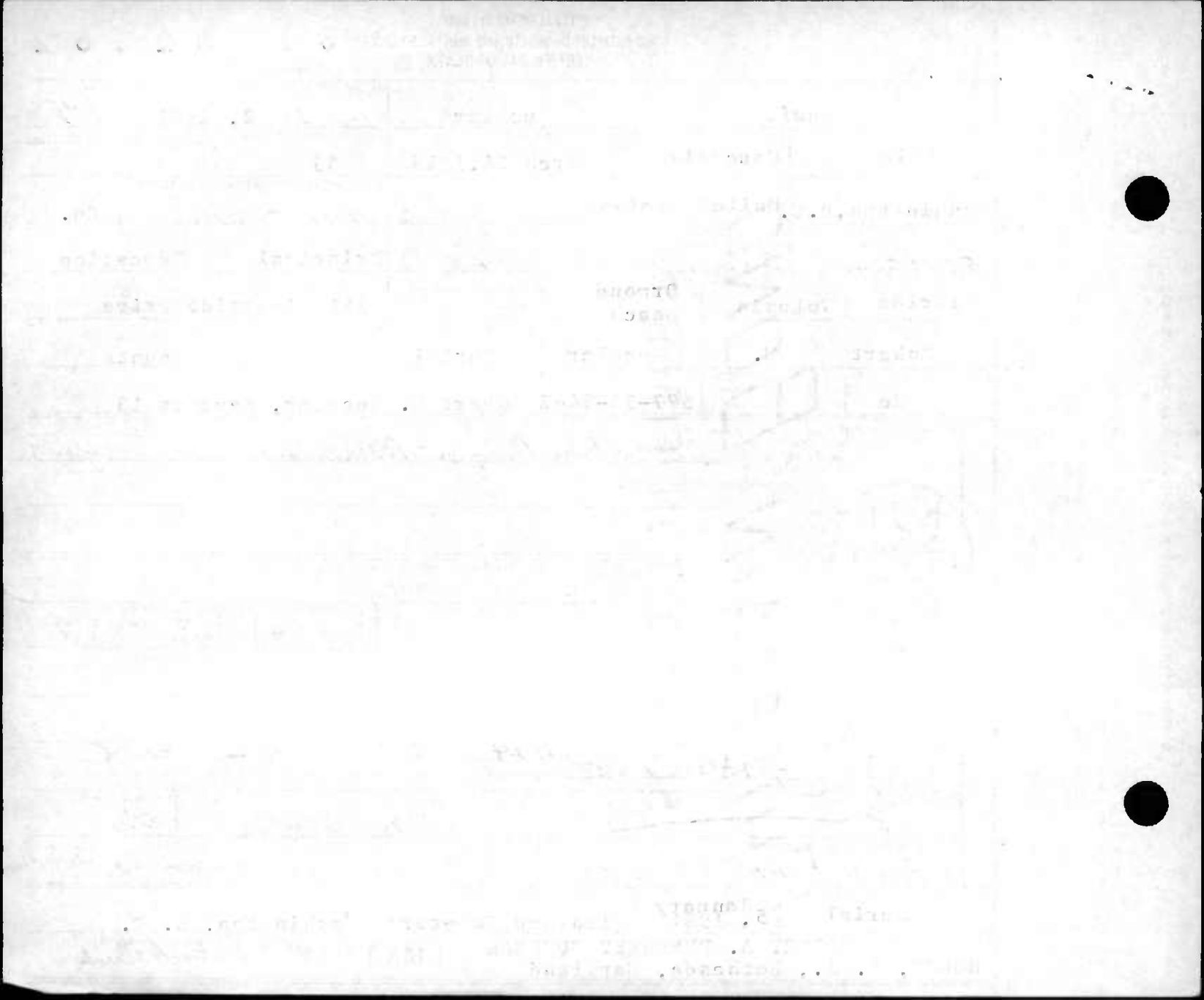
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 2 3 6 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dennis Reardon Buckler				2a. DATE OF DEATH MONTH DAY YEAR January 2, 1981		2b. HOUR 1:45 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 24, 1945		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Principal		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Florida		13b. COUNTY Volusia		13c. ORMOND BEACH		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert M. Buckler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muriel Counts		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 577-58-6467		17. INFORMANT ADDRESS Robert M. Buckler, Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Melanoma 1729 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH = 4 years							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/29 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 11516 OLD GEORGETOWN RD, ROCKVILLE			
22a. I certify that (I) (this hospital) attended the deceased from 12/29 19 80 to 1/2 19 81 , that (I) (we) lost saw the deceased alive or above, (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED 1/2/81
22b. SIGNATURE S. RALPH H. HANCOCK				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 1/2/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. RALPH H. HANCOCK				22e. ADDRESS 11516 OLD GEORGETOWN RD, ROCKVILLE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE January 5, 1981		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 12 1981		25b. REGISTRAR'S SIGNATURE Robert M. Buckler	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

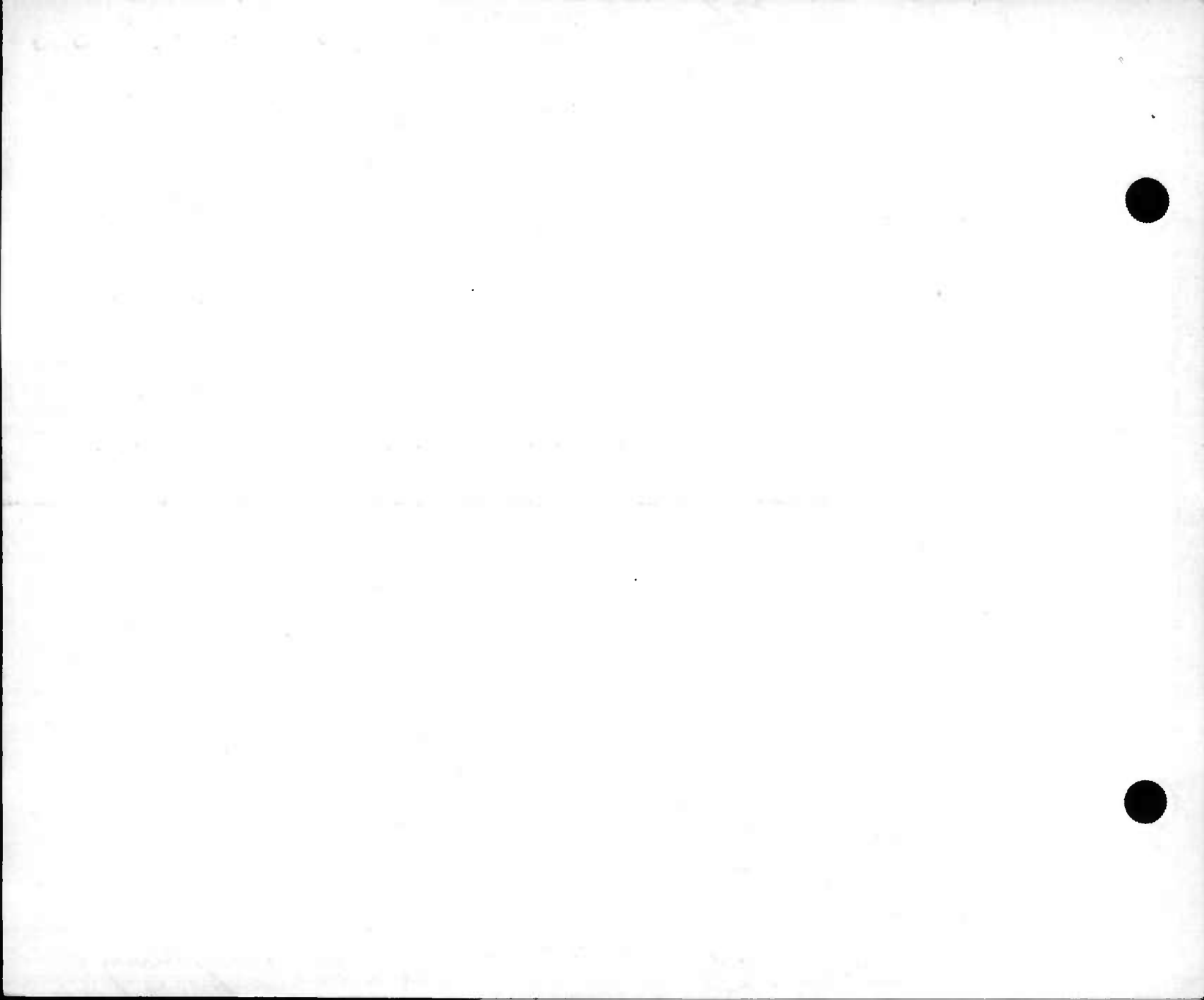
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
James Platt Bull, Jr.			Jan.			26			1981			8:AM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
Male			White			11 MONTH 14 DAY 1921			59			MONTHS			DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. YRS.			11. MONTHS		
New York			USA						Montgomery								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF INDUSTRY			13. ADDRESS			14. CITY OR TOWN		
Silver Spring			2103 Hildarose Drive,			Retired ADM.			University								
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15b. STATE			15c. COUNTY			15d. CITY OR TOWN			15e. INSIDE CITY LIMITS?			15f. STREET ADDRESS		
Maryland			Montgomery			Silver Spr			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2103 Hildarose Drive,					
16. FATHER'S NAME			17. MOTHER'S MAIDEN NAME			18. INFORMANT (WIFE)			19. ADDRESS			20. DATE OF OPERATION			21. CONDITION FOR WHICH OPERATION WAS PERFORMED		
James P. Bull, Sr.			Ella Perry			Dorothy S. Bull- (same as 13e)											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT (WIFE)			19. ADDRESS			20. DATE OF OPERATION			21. CONDITION FOR WHICH OPERATION WAS PERFORMED		
yes			WW 11			577-20-6451			Dorothy S. Bull- (same as 13e)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			19. IMMEDIATE CAUSE (a)			20. DUE TO, OR AS A CONSEQUENCE OF			21. DUE TO, OR AS A CONSEQUENCE OF			22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4100			Acute Myocardial Infarction									1 day					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			24. DIABETES Mellitus, Chronic Renal Failure														
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a. DATE OF OPERATION			24b. TIME OF INJURY			24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			24e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			24f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura BURDEN			2a. DATE OF DEATH MONTH DAY YEAR January 3 1981		2b. HOUR 12:54A		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 2, 1981		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 25	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13f. STREET ADDRESS Virginia Arlington Arlington YES NO 1121 Arlington Blvd. Apt. T601							
14. FATHER'S NAME FIRST MIDDLE LAST Robert Talmadge Burden III				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Marie Biven			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Sharon M. Burden See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Extreme prematurity IMMEDIATE CAUSE (a) 7650 DUE TO, OR AS A CONSEQUENCE OF (b) non-viable fetus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 2 1981 to Jan 3 1981 , that (I) (we) lost Jan. 3 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. H. NADING, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 6, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. NADING, M.D.		22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY National Naval Med. Center		23d. LOCATION (CITY OR TOWN) COUNTY STATE Bethesda Montgomery Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rachael BURDEN			2a. DATE OF DEATH MONTH DAY YEAR January 3 1981			2b. HOUR 3:38A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 2 1981		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3 07		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Virginia		13b. COUNTY Arlington		13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1121 Arlington Blvd. Apt. T601	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Talmadge Burden III					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Marie Biven				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Mrs. Sharon M. Burden See item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme prematurity 7650 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Non-viable fetus DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I/ (this hospital) attended the deceased from Jan. 2 1981 to Jan. 3 1981 , that (I/ (we) lost saw the deceased alive on Jan. 3 1981 , and that in (my/ (our) opinion death occurred on the date and hour and from the causes stated above. (I/ (we) (did) (did not) see the body after death.									
22b. SIGNATURE J. H. Nading, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Jan. 6, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. Nading, M.D.					22e. ADDRESS National Naval Medical Center, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY National Naval Med. Center Bethesda Montgomery Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR JAN 10 1981		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

1952

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 6 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILLIE M. BURDETTE			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1981		2b. HOUR 4:50p M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 23409 Woodfield Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel V. Broadhurst		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline C. Watkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 215-46-4916	17. INFORMANT ADDRESS Laura B. Sumner, Item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u> 4241 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Stenosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>81</u> , to <u>1/29</u> , 19 <u>81</u> , that (I/we) lost saw the deceased alive on <u>1/29</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alberto Rotztein</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/29/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALBERTO ROTZTEIN, M.D.</u>		22e. ADDRESS <u>10401 Old Georgetown Rd # 305 Bethesda, Md 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 1, 1981	23c. NAME OF CEMETERY OR CREMATORY Wesley Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Woodfield Montgomery, Md.	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.		ADDRESS		25. DATE RECEIVED BY REGISTRAR FEB 1 1981	
				26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

This certificate must be completed at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802

10. 10, 1802



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 6 7

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	JAN 15, 1981		2:01 A.M.
Margaret L. Burgston							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female	White	Jan 14 1903		78 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash., D. C.	USA			Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Carriage Hill Nursing Home		Ret. Clerk -		Navy Dept.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
D. C.			Washington	YES <input type="checkbox"/> NO <input type="checkbox"/>	2008 Hayden Road		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Frank T. Miller		Isabelle Gunson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		579-03-3831		3556 South River Terrace, Edge- David A. Dryer, Cousin, water, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> <u>1830</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY METASTASES</u> (c) <u>OVARIAN CARCINOMA</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>6 MONTHS</u> <u>8 MONTHS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>73</u> to <u>JAN 15</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>JAN 14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Dennis F. Hand</u>		MD				1/15/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
DENNIS F. HAND MD		4600 CONNECTICUT AVE NW. WASH. DC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1-19-81	Cedar Hill Cem.		Suitland, P.G., Maryland		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robt E Wilhelm		4308 Suitland Rd., Suitland, Md.		JAN 21 1981			

BP

RECEIVED

1972

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 2 3 6 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Adolphus B. Burton</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-20-81</i>			
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 12, 1886</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>94</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Printer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Roderick S. Burton</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-44-0820</i>		17. INFORMANT ADDRESS <i>Walter J. Royer, Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Coronary Artery Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>11</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Stroke</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1/20 1981</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)			
21d. INJURY OCCURRED WHEN AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/20 1981</i> to <i>1/20 1981</i> that (I) (we) last saw the deceased alive on <i>1/20 1981</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. G. Ward</i> DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/21/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. G. Ward</i>				22e. ADDRESS <i>6116 Rockville Pike, Bethesda, MD 20830</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>23 1981 January</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bethesda, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony M. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude M. BUTLER										2a. DATE OF DEATH MONTH DAY YEAR January 21 1981		2b. HOUR 8:15P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 29, 1912		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 68		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY Gov't.					
13a. STATE Maryland		13b. COUNTY St. Marys		13c. CITY OR TOWN California		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 518 Garrison Drive					
14. FATHER'S NAME FIRST MIDDLE LAST Alexander MacDonal'd						15. MOTHER'S MAIDEN NAME FIRST MIDDLE Georgina James Soutar							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 18 4806		17. INFORMANT Wallace K. Butler				ADDRESS See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 90 minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive Heart Failure, Acute Renal Failure, Pseudomonas Sepsis													
19a. DATE OF OPERATION Jan 21 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26 19 80 , to Jan. 21 19 81 , that (I) (we) last saw the deceased alive on Jan. 21 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert W. Sharpe MD						DEGREE LT MC USNR ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 22, 1981					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT W SHARPE MD						22e. ADDRESS National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Jan. 24, 1981		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE California St. Marys Md.							
24. FUNERAL DIRECTOR NAME Mattingley						25a. DATE REC'D. BY REGISTRAR JAN 26 1981		25b. REGISTRAR'S SIGNATURE Barney McCreedy					
26. FUNERAL HOME ADDRESS Mattingley Funeral Home Leonardtown, Md.													

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 2 3 7 0			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Lula Byrd Caldwell				MONTH DAY YEAR 1/14/81			
3. SEX Female				2b. HOUR 2135 ^M			
4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR JULY 5, 1897			
6. AGE (IN YEARS LAST BIRTHDAY) 83				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY			
13c. CITY OR TOWN GAITHERSBURG				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 201 RUSSELL AVENUE							
14. FATHER'S NAME FIRST MIDDLE LAST LAWRENCE DeATLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA KING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-32-5593			
17. INFORMANT DAUGHTER				ADDRESS LULA C. BEATTY RT 1, BOX 164B, SHARPSBURG MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> 2396 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months ylnw
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION 12/31/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14/80</u> to <u>1/14/81</u> , that (I) (we) last saw the deceased alive on <u>1/14/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Thos G. WARD				DEGREE M.D.		22c. DATE SIGNED 1/13/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD				22e. ADDRESS 616 Robinson Rd, Bethesda MD.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/17/81		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION ROCKVILLE MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 16 1981		25b. REGISTRAR'S SIGNATURE Ester A. Kelly	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH: 16 1/71 30M
(VR A15 (4))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 2 3 7 1

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <u>Stella B. Cameron</u> | | | 2a. DATE OF DEATH
Month <u>01</u> Day <u>08</u> Year <u>81</u> | | | 2b. HOUR
<u>10: P M</u> | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>Sept 18, 1896</u> | | 6. AGE (In years last birthday)
<u>84</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>England</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>Great Britain</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>15300 Wallbrook Ct.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>retired Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Nd</u> | | 13b. COUNTY <u>Mont.</u> | | 13c. CITY OR TOWN
<u>Silver Sp.</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>15300 Wallbrook Ct.</u> | |
| 14. FATHER'S NAME First Middle Last
<u>Francis Hill</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>Cornelia Crickmore</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT <u>Wash.D.C. 20002</u>
<u>Adrienne C. Boniface-daughter 15 Brown Ct. S.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<u>4960</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Chronic obstructive Lung disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>11 hrs.</u>
<u>11/3/77</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Coronary Heart Failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, natlty medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>77</u> , to <u>1/8/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Alberto Rotsztein</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/9/81</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Alberto Rotsztein, M.D.</u> | | 22e. ADDRESS
<u>3701 Rossmanor Blvd. S.S. Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 23b. DATE
<u>1-9-81</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lee's Crematory</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C. 20002</u> | | | |
| 24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> ADDRESS
<u>300-4th St. N.E. Washington, D.C. 20002</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 13 1981</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

RECEIVED



See how the M. S. Anderson, D. O. 2005
See how the M. S. Anderson, D. O. 2005
See how the M. S. Anderson, D. O. 2005

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 7 2

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) AIKEN S CAMPBELL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-6-81 | | 2b. HOUR 11A M. | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 9, 1898 | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 12. CITY OR TOWN OF DEATH
Silver Spring | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
OPERATOR | | 15. KIND OF BUSINESS OR INDUSTRY
WESTERN UNION | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE MARYLAND 16b. COUNTY MONTGOMERY 16c. CITY OR TOWN SILVER SPRING 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 17. STREET ADDRESS
10627 EASTWOOD AVENUE | | | |
| 18. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT J. MCGOWAN | | 19. MOTHER'S MAIDEN NAME
FIRST MIDDLE
SARAH MCGOWAN | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 21. SOCIAL SECURITY NO.
209-07-8844 | | 22. INFORMANT ADDRESS
MARY D. MUCCINO SAME AS 13 DAUGHTER | | |

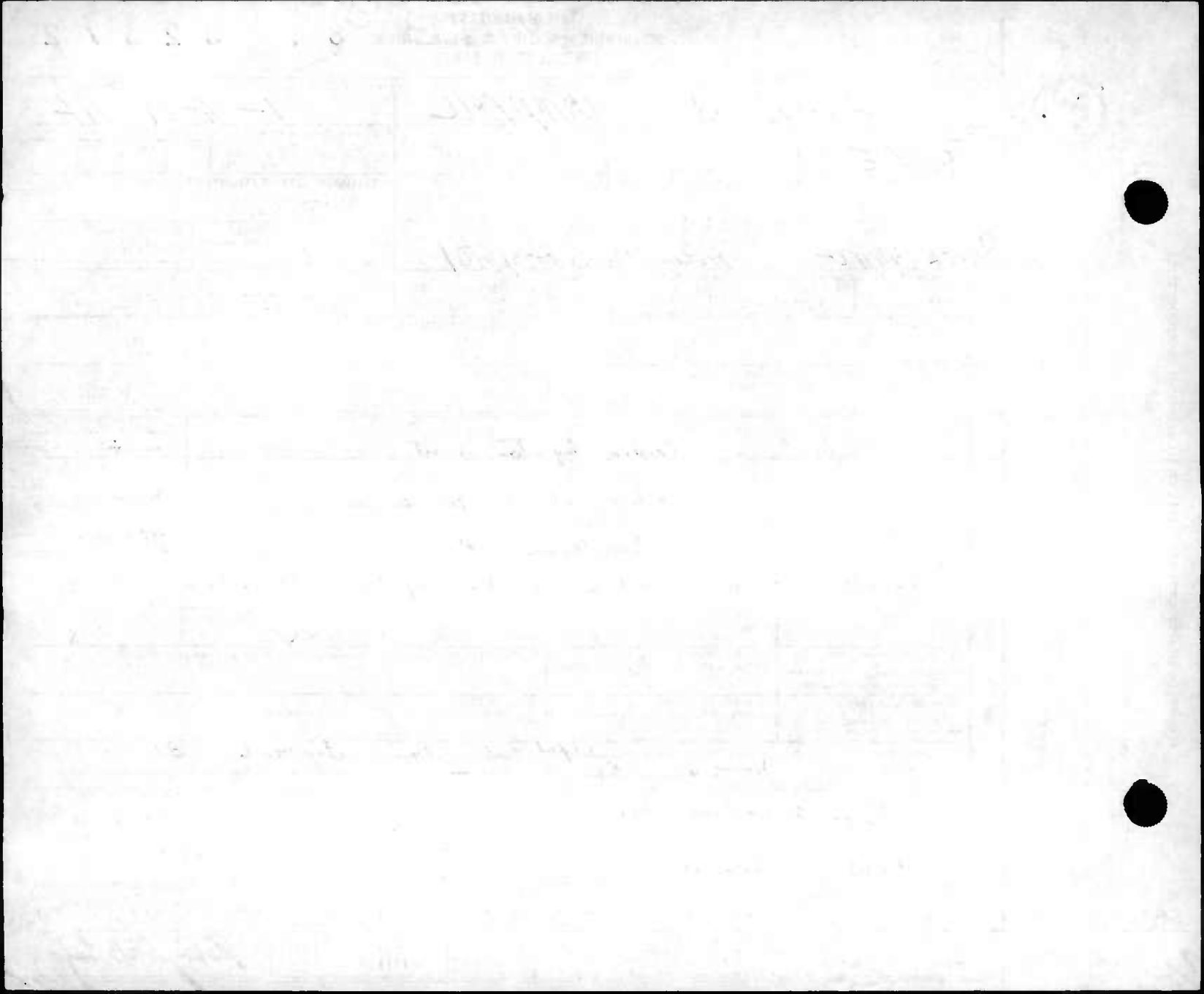
| | | | | | |
|--|--|---|--|---|----------------------------------|
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordis Aneurysm Aortic
4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Cordis Pulmonary Failure
(c) Atherosclerosis | | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
years
years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Emaciation Anorexia Osteoporosis Atrial Hypertension Pharynx URT | | | | | |
| 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 31. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 32. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 34. I certify that (I) (this hospital) attended the deceased from April 15, 1976 to January 6, 1981 , that (I) (we) last saw the deceased alive on January 6, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 35. SIGNATURE
Hugo G. Graziani M.D. | | | 36. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 37. DATE SIGNED
1-6-81 |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)
Hugo G. Graziani | | | 39. ADDRESS
800 Pennington Dr. 303A
SS Md 20910 | | |

| | | | |
|---|---------------------------|--|--|
| 40. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 41. DATE
1/9/81 | 42. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | 43. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. |
| 44. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 45. DATE REC'D. BY REGISTRAR
JAN 12 1981 | 46. REGISTRAR'S SIGNATURE
Robert McHenry |
| 47. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

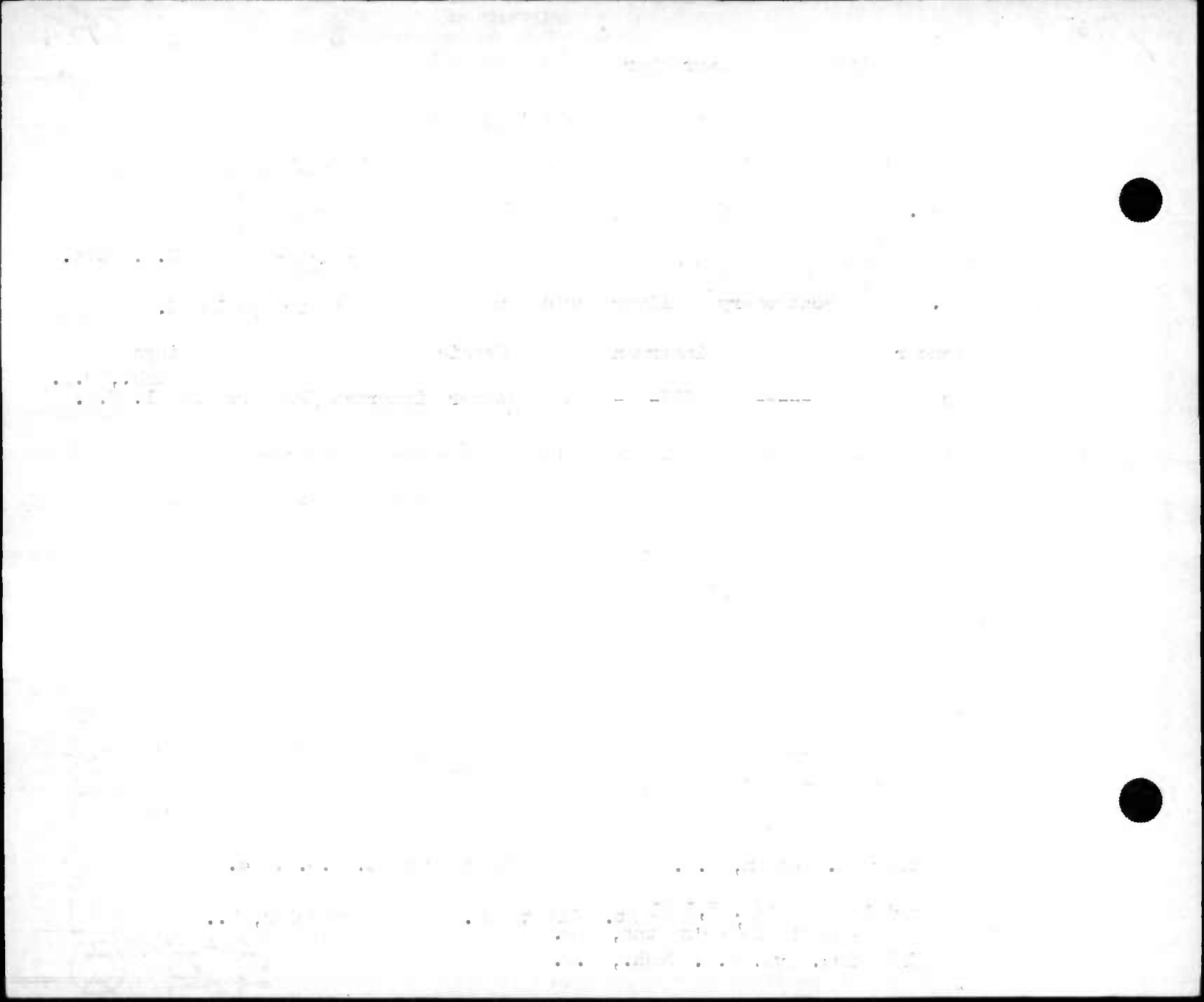
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8102373 | |
|---|--|---|---|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
RALPH LEONARD CAPLAN | | | 2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 27, 1981 | | 2b. HOUR
5:20 AM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
APRIL 3, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ACCOUNTANT | 12b. KIND OF AGENCY OR INDUSTRY
ADVERTISING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
SAMUEL CAPLAN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
MOLLY ABRAHAM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
213-38-2822 | 17. INFORMANT ADDRESS
LILLIAN CAPLAN, same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u>
4149
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CORONARY ART. DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 hours | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>JAN 26</u> , 19 <u>81</u> , to <u>JAN 27</u> , 19 <u>81</u> , that (1) (we) lost
saw the deceased alive on <u>JAN 27</u> , 19 <u>81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated
above, (1) (we) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Jamet Ronan</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMET RONAN | | 22e. ADDRESS
7600 CARROLL AVE. TAKOMA PK, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | 23b. DATE
1/28/1981 | 23c. NAME OF CEMETERY OR CREMATORY
JUDEAN MEMORIAL GARDENS | 23d. LOCATION
OLNEY, MONTGOMERY, MARYLAND | | |
| 24. PREPARED BY
DONALD STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 25. DATE REC'D. BY REGISTRAR
JAN 30 1981 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR Alice Carragher | | REG. NO. 81 02374 | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Alice Carragher | | | | | 2a DATE OF DEATH MONTH DAY YEAR HOUR
1 1 81 520 PM | | | | |
| 3 SEX
FEMALE | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 24 97 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.
83 | | IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b CITIZEN OF WHAT COUNTRY?
US | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerical | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 13a STATE
Md. | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Silver Spring | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
8505 Springvale Rd. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Spencer Zimmerman | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jessie Riggs | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
577-50-9426 | | 17 INFORMANT ADDRESS
Spencer Zimmerman 3286 Arcadia Pl. N.W. Wash., D.C. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 4310
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION, ATHEROSCLEROSIS 10 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) 2 DAYS | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
DIABETES MELLITUS | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1975 to JAN 1 1981, that (I) (we) saw the deceased alive on JAN 1 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Edward A. Beeman | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
JAN 1, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward A. Beeman, M.D. | | | | 22e. ADDRESS
8830 Cameron St. S.S., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 5, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Frederick, Md. | | | |
| 24 FUNERAL DIRECTOR NAME
Joseph Gawler's Sons, Inc. | | | | ADDRESS
5130 Wisc. Ave. N.W. Wash., D.C. | | 25. DATE REC'D BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
Barbara M. Brady | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 3 7 5 | |
|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Alice Thelma Carroll</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>1 2 81</i> | | 2b. HOUR
<i>10:13 AM</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>5 24 1908</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>73</i> YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Co. MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Store Detective</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Retail</i> |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Mont.</i> | 13c. CITY OR TOWN
<i>Bethesda</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Harry Lee Chalkley</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Alma Lippold</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>215-10-3131</i> | | 17. INFORMANT
ADDRESS
<i>Gerard E Rogers 8511 Pelham Rd 20034</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>pneumonia, viral</i>
4870 DUE TO, OR AS A CONSEQUENCE OF
(b) <i>influenza</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 d</i>
<i>4 d</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <i>1/1</i> , 19 <i>77</i> , to <i>1/2</i> , 19 <i>81</i> , that (1) <i>we</i> last saw the deceased alive on <i>1/1</i> , 19 <i>81</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (1) <i>we</i> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Lewis N Cahill</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1/2/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>LEWIS N CAHILL M.D.</i> | | 22e. ADDRESS
<i>5411 W. CEDAR CN. BETHESDA, MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1-5-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Dulaney Valley Mem Gar</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Mitchell-Wiedefeld Home</i> | | ADDRESS
<i>6500 York Rd 21212</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Lutherville Balto Maryland</i> | |
| 25a. DATE REC'D. BY REGISTRAR
<i>JAN 8 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02376

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM FIELDS CAVENESS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN 24 1981 | | 2b. HOUR
0338 M | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 13 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ZEBULON N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NNMC | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PHYSICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
BETHESDA | | 13c. STREET ADDRESS
4977 BATTERY LANE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ZEBULON MARVIN CAVENESS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CORINNA MARY JONES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
51-72 | | 17. INFORMANT
ADDRESS Bethesda, Md.
WIFE-ANGELA S. CAVENESS 4977 BATTERY LN | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF THE COLON
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from Dec. 30 , 19 80 , to Jan. 24 , 19 81 , that (I) we saw the deceased give an Jan. 24 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
G.F. Worsham | | | | 22c. ADDRESS
Box 162, NNMC, Bethesda, Md. 20014 | | 22d. DATE SIGNED
25 Jan 81 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
January 27 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Raleigh, North Carolina | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Robert A. Pumphrey</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

U.S. 100

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report.]

Very truly yours,
[illegible signature]
[illegible title]
[illegible address]
[illegible phone number]
[illegible fax number]
[illegible email address]

100-101100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 7 7

REG. NO.

| | | | | | | | | | |
|--|--|---|---|--|---|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) <i>Andrew NMI Carrico Jr</i> | | | 2a DATE OF DEATH MONTH DAY YEAR
<i>1-14-81</i> | | | 2b HOUR
<i>3:54 AM</i> | | | |
| 3 SEX
<i>Male</i> | | 4 RACE
<i>Cau.</i> | | 5 DATE OF BIRTH
MONTH DAY YEAR
<i>May 18 1892</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>88</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7c CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10 CITY OR TOWN OF DEATH
<i>Kensington</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Kensington Gardens Nursing Home</i> | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b KIND OF BUSINESS OR INDUSTRY
<i>Federal Agent</i> | |
| 13a STATE
<i>Maryland</i> | | | 13b COUNTY
<i>Montgomery</i> | | 13c CITY OR TOWN
<i>Rockville</i> | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>Andrew NMI Carrico, Sr.</i> | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Virginia Luckett</i> | | | 16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>12630 Viers Mill Road 20853</i> | | | |
| 14a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 14b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
<i>WWI</i> | | 17 INFORMANT
ADDRESS
<i>Son-Andrew Carrico III</i>
<i>6911 Cabin John Rd., Sprf. Va. 22150</i> | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <i>Arteriosclerosis</i>
(c) <i>Chronic hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>7 years</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>December 11 1980</i> to <i>January 14 1981</i> , that (I) (we) last saw the deceased alive on <i>December 12 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | |
| 22b SIGNATURE
<i>Benjamin J. Armin, MD</i> | | | DEGREE
<i>MD</i> | | | 22c DATE SIGNED
<i>1-14-81</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Benjamin J. Armin</i> | | | 22e ADDRESS
<i>3720 Fennelwood Ave. NW, NW 20255</i> | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | | 23b DATE
<i>Jan 17 81</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Lee's Crematory</i> | | 23d LOCATION
CITY OR TOWN COUNTY STATE
<i>Washington D.C.</i> | | |
| 24 FUNERAL DIRECTOR
NAME <i>Wayne F. Zebert</i> ADDRESS
<i>Demaine Funeral Home, Alexandria, Va. 22314</i> | | | 25a DATE REC'D BY REGISTRAR
<i>JAN 19 1981</i> | | 25b REGISTRAR'S SIGNATURE
<i>Anthony McCrory</i> | | | | |

17-50

8

RECEIVED
JAN 17 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

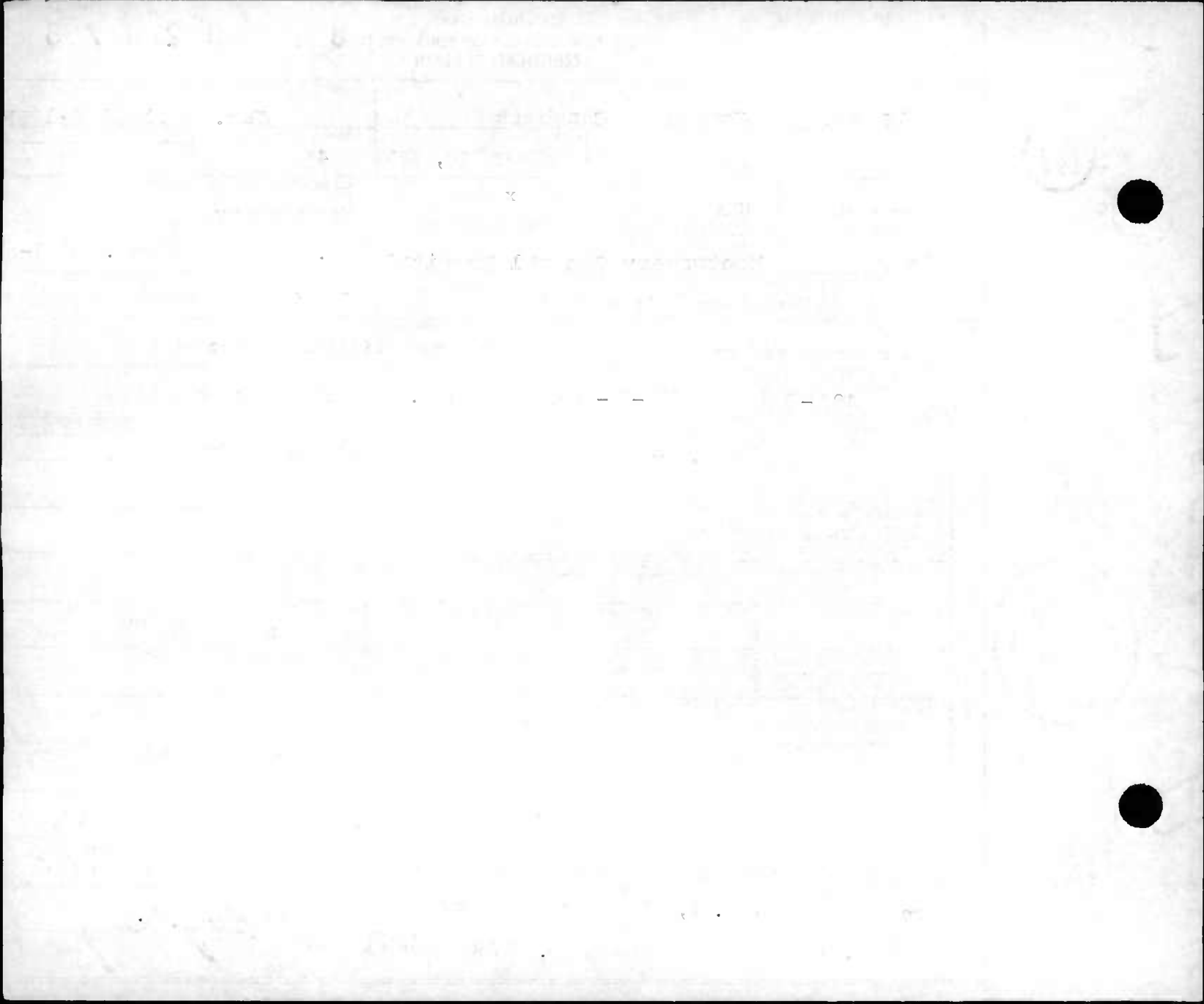
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Walter Joseph Chambers | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 10, 1981 | | 2b. HOUR
6:12 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 20, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Pub. Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Tech. Publications |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
3 Pinebrook Court | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Joseph Warner | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Lillian Goodwill | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
19524955 | | 17. INFORMANT
ADDRESS
Laurie S. Chambers Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of breast with metastases</u>
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>80</u> , to <u>1/10</u> , 19 <u>81</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1/10</u> , 19 <u>81</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I) (we)</u> did not view the body after death. | | | | | |
| 22b. SIGNATURE
<u>John G. Loomell, MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
1/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN G. LOOMELL, MD | | 22e. ADDRESS
1811 PRINCE PHILIP DR. OLNEY MD | | 22f. ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jan. 11, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | |
| 23d. LOCATION
CITY OR TOWN
Washington D. C. | | 23e. COUNTY
District of Columbia | | 23f. STATE
D.C. | |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20760 | | 25. DATE RECD. BY REGISTRAR
JAN 14 1981 | | | |
| 26. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

0 2 3 7 9

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) William D Clark | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 17 81 | | 2b. HOUR
1:10 M |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 31 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Hickman | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SUGAR Ref Plummer | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MD AA Northland | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
888 Bayfront Hillmont Point | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry G Clark | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucina Warfield | | ADDRESS
Widdort Md | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
578070939 | | 17. INFORMANT
Elton R Farmer | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1639
IMMEDIATE CAUSE (a) Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|---|--|--|---|
| 19a. DATE OF OPERATION
2 9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1980 , 19____, to 4/17/81 , 19____, that (I) (we) lost
saw the deceased alive on 1/16/81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William Ware | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Ware | | 22e. ADDRESS
14300 Ballant Fox Lane Bowie Md | | | |

| | | | |
|---|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Jan 20 81 | 23c. NAME OF CEMETERY OR CREMATORY
Providence cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Gleneden Howard Md |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Newrock Funeral Home | | 25. JAN 22 1981 REGISTRAR'S SIGNATURE
[Signature] | |

1917

July 1st

July 2nd

July 3rd

July 4th

July 5th

July 6th

July 7th

July 8th

July 9th

July 10th

July 11th

July 12th

July 13th

July 14th

July 15th

July 16th

July 17th

July 18th

RECEIVED
JUL 19 1917
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WYOMING STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 2 3 8 0

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--------------------------------|--|----------------|--|----------|--|
| 1. FOR
STATE
REGISTRAR | | FOR
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 0 2 3 8 0 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | MONTH DAY YEAR | | 2b. HOUR | | | |
| HERSCHEE | | F. | | CLESNER | | | | JAN 1 1981 | | 7:15 | | AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | | MONTH DAY YEAR | | 2d. HOUR | |
| MALE | | WHITE | | MAY 26 1923 | | 57 YRS. | | | | 1 1 19 81 | | 7 AM | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| MASS. | | USA | | | | MONTGOMERY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | |
| SILVER SPRING | | HOLY CROSS HOSPITAL | | ATTORNEY | | U.S. GOVT. | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | | | YES | | 710 LAMBERTON ST. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | |
| MICHAEL | | CLESNER | | SARAH | | FEDERMAN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| YES | | W.W. II | | 002-14-4511 | | JENNIE CLESNER (SEE ITEM #13) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
4100
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) <u>CORONARY ARTERIOSCLEROSIS</u>
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>ACUTE</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 5-6 PM 1-1 1981 | | 5-6 PM 1-1 1981 | | COLLAPSED AT HOME | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| HOME | | HOME | | 710 LAMBERTON ST SILVER SPRING MONT MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Francis C. Mayle Jr</u> | | TITLE (SPECIFY)
M.D. <u>Dpt</u> | | MEDICAL EXAMINER | | DATE SIGNED <u>11/1/81</u> | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) <u>FRANCIS C. MAYLE JR</u> | | ADDRESS <u>20014 WISCONSIN AVE BETHESDA MD</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| BURIAL | | Jan 4, 1981 | | Judean Gardens | | Norbeck, Montgomery MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| W.W. CHAMBERS CO. SILVER SPRING MD | | JAN 1 1981 | | [Signature] | | | | | | | | | | | |

[Faint, illegible text throughout the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 3 8 1 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DORIS VIRGINIA COCIMANO | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 81 | | 2b. HOUR 4 35 PM | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 1 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY PG | | 13c. CITY OR TOWN Upper Marlboro | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William J. Miller | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian K. Diggs | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None | | 16b. SOCIAL SECURITY NO. 577 01 2874 | | 17 INFORMANT ADDRESS Joyce Yore (Daughter) Same as above | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiogenic shock
DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia with respiratory failure | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
systemic lupus erythematosus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (this hospital) attended the deceased from Dec 12 1980 to Jan 12 1981 , that I saw the deceased alive on 1-12 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE John Kijak DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-12-81 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) John Kijak | | | | 22e. ADDRESS 344 University Blvd. W. SS. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. ADDRESS 11800 N.H. Ave. S.S. Md. | | | | 25. BALTIMORE REGISTRAR'S SIGNATURE [Signature] | | | |

1850

18

1850

1850

18

1850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 3 8 2

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
SAMUEL WILLIAM COHEN | | | 2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 27, 1981 | | 2b. HOUR
7:30 A.M. | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR
APRIL 22, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
77 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
POTOMAC VALLEY NURSING HOME | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
TAXI CAB | | |
| 13a. STATE
D. C. | | 13b. COUNTY
none | | 13c. CITY OR TOWN
WASHINGTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1327 ALLISON STREET, N. W. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
MAX COHEN | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
IDA (UNASCERTAINABLE) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-30-7292 | | 17 INFORMANT ADDRESS
BERNARD HERBERT COHEN, 11012 HANEY TERRACE,
DAMASCUS, MARYLAND | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of colon</u>
1539
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>Walter E. Goozh</u> attended the deceased from <u>23-Jan-81</u> to <u>27-Jan-81</u> , that (I) <u>last</u> saw the deceased alive on <u>26-Jan-81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>not</u> seen, did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter E. Goozh M.D.</u> | | | DEGREE
M.D. | | | 22c. DATE SIGNED
27 Jan 81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. WALTER E. GOOZH, M. D. | | | 22e. ADDRESS
2309 SHOREFIELD ROAD, WHEATON, MARYLAND | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1/28/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
OHEV SHOLOM TALMUD TORAH CONGREGATION CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON D. C. | | |
| 24 FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02383 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
FIRST Oswald MIDDLE Symister LAST Colclough | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 1981 | |
| 2b. HOUR A | | | | | | | | | | 2c. DATE PRONOUNCED DEAD
MONTH 1 DAY 26 YEAR 1981 | |
| 3. SEX Male | | | | | | | | | | 4. RACE CAUC | |
| 5. DATE OF BIRTH
MONTH 11 DAY 19 YEAR 1981 | | | | | | | | | | 6. AGE (IN YEARS)
LAST BIRTHDAY 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
25 GRAFTON St | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NAVAL OFFICER | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
USA | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN CHEVY CHASE | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
25 GRAFTON St | | | | | | | | | | 14. FATHER'S NAME
FIRST William MIDDLE Frederick LAST Colclough | |
| 15. MOTHER'S MAIDEN NAME
FIRST Sara MIDDLE -- LAST Cooper | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
Yes | |
| 16b. SOCIAL SECURITY NO.
1920 - 1050 | | | | | | | | | | 16c. 579-44-1243 | |
| 17. INFORMANT
Kathleen B. Colclough, Same as # 13. | | | | | | | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
4100 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
10 YRS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION
-- | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
-- | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1 26 1981 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
DIED IN BED | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | |
| 21f. LOCATION
STREET 25 GRAFTON St CITY OR TOWN CHEVY CHASE COUNTY MONT STATE MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayle TITLE (SPECIFY) DEPT MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 1/26/81 | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE ADDRESS 820 Wisconsin Ave Bethesda MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 1/29/81 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | | | | | | | | | 23d. LOCATION
CITY OR TOWN Arlington, Virginia COUNTY ARLINGTON STATE VA | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1981 | |
| 25b. REGISTRAR'S SIGNATURE Robert McBrady | | | | | | | | | | | |

00000 00-0

010

742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

0201 - 0521

22

Johnston, William

• *Indica*

TONSKI

Figure 1

Joseph G. ... Inc.

3505 S. 4th, Northridge, CA 91324, (818) 708-0512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 8 4

REG. NO.

| | | | | | |
|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LUCY F COLETTI | | | 2a. DATE OF DEATH MONTH 1 DAY 3 YEAR 81 | | 2b. HOUR 10²⁰ A.M. |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH Oct DAY 8 YEAR 1897 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Wheaton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST Antonio MIDDLE LAST Coletti | | 15 MOTHER'S MAIDEN NAME
FIRST Donato MIDDLE LAST Cugini | | 13e. STREET ADDRESS
11808 Claridge Road | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO
021-50-7847 | | 17 INFORMANT
Marie Sandridge ADDRESS
Same as #13 | |

| | | | | | |
|---|--|--|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute respiratory distress syndrome 4100 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiogenic shock | | | | days | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Acute myocardial infarction | | | | days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Cerebrovascular accident | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-21 , 19 80 , to Jan 3 , 19 81 , that (I) (we) last saw the deceased alive on Jan 2 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Margaret S. Choa | | | | 22c. DATE SIGNED
1-3-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARGARET S. CHOA | | | | 22e. ADDRESS
1111 Spring St Silver Spring 20910 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Wollaston Cem. | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | 23d. LOCATION
CITY OR TOWN
Quincy | | 23e. STATE
Massachusetts | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 5 1981 | | | | 25b. REGISTRAR'S SIGNATURE
Robert McCreedy | |

[Faint, illegible text, likely bleed-through from the reverse side of the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 8 5

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MABEL D. COMFORT | | 2r. DATE OF DEATH MONTH DAY YEAR
Jan 7-81 | | 2b. HOUR
1432M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2-08-00 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12r. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS DOYLE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARTHA SUMMERS | | 16. ADDRESS
2209 PARALLEL LANE
SILVER SPRING, MD. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
495-32-4307 | | 17. INFORMANT
SON
ROBERT T. COMFORT | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>S.P.H.I. - CHF</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/5/81</u> 19 <u>81</u> to <u>1/7</u> 19 <u>81</u> , that (I) (we) last
saw the deceased alive on <u>1/30</u> <u>17</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/7/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. KALDUN, NOSSOLI | | 22e. ADDRESS
11500 OLD GEORGETOWN RD - ROCKVILLE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
ENTOMBMENT | | 23b. DATE
1/12/81 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK GROVE MAUSOLEUM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ST. LOUIS ST. LOUIS MO | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES OF THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02386 | | | |
|---|--|------------------------|--|---|--|--|--|--|--|--|--|--------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Denis NMI Conroy | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1-28 1981 | | 2b. HOUR 7 M | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 12 6 27 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 53 YRS | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | | | 7b. CITIZEN OF WHAT COUNTRY? England | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Seneca | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) C + O Canal Pdd. Mont Lock | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Ashton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 17958 Pond Road | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Conroy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Connor | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 265-58-6868 | | 17. INFORMANT ADDRESS Iris E. Conroy, Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun Shot Wound of head.
9550 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which }
gave rise to immediate }
cause (a) stating the under- }
lying cause last. }
(b) Self inflicted.
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 29 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot Self through mouth with hand gun. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) C + O Canal | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Pentmont Lock Seneca Mont MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | TITLE (SPECIFY) M.D. Deputy | | | | DATE SIGNED Jan 28, 1981 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D. | | | | ADDRESS Bethesda, Maryland 20014 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 1/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1981 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

(10)

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 3 8 1 | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>BERTHA ANNA COOK</i> | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1 - 16 - 81</i> | | 2b. HOUR
<i>10 a.m.</i> | |
| 3 SEX
<i>FEMALE</i> | | 4 RACE
<i>WHITE</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>AUG. 9. 1906</i> | | | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.
<i>74</i> | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>PENNA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>TAKOMA PARK</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOMEMAKER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>HOW.</i> | | 13c. CITY OR TOWN
<i>FULTON</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>8509 BEAUFORT DRIVE</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>JACOB BUTKER</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>ANNA STRITZEL</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>370-40-1505</i> | | 17 INFORMANT
<i>CAROL L. COOK</i> | | | | ADDRESS
<i>8509 BEAUFORT DR</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Small Cell Carcinoma</i>
<i>1991</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 mos</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Pleural Effusion; Atelectasis</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/13</i> 19 <i>80</i> , to <i>1/16</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/15/81</i> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Joseph E. Smith Jr.</i> | | | | DEGREE
<i>M.D.</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/16/81</i> | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JOSEPH SMITH JR</i> | | | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Jan. 20. 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Spring Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Camden Penn</i> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
<i>Takoma Funeral Home</i> | | | | ADDRESS
<i>224 Carroll St</i> | | | | 25. DATE RECD. BY REGISTRAR IN REGISTRAR'S SIGNATURE
<i>1/20/81</i> | | | | | |

BP



The following is a list of the names of the persons who have been
 named in the will of the late John Smith, deceased, as
 recorded in the probate court of the County of [blank], State of
 [blank], on the [blank] day of [blank], 19[blank].

| Name | Relationship | Age | Sex | Color | Married | Single | Widowed | Divorced | Other |
|-----------------|--------------|-----|--------|-------|---------|--------|---------|----------|-------|
| John Smith | Testator | 65 | Male | White | | | | | |
| James Smith | Son | 35 | Male | White | | | | | |
| Mary Smith | Daughter | 30 | Female | White | | | | | |
| Robert Smith | Son | 25 | Male | White | | | | | |
| Elizabeth Smith | Daughter | 20 | Female | White | | | | | |
| William Smith | Son | 15 | Male | White | | | | | |
| Anna Smith | Daughter | 10 | Female | White | | | | | |
| Thomas Smith | Son | 5 | Male | White | | | | | |
| John Smith | Son | 40 | Male | White | | | | | |
| Mary Smith | Daughter | 35 | Female | White | | | | | |
| Robert Smith | Son | 30 | Male | White | | | | | |
| Elizabeth Smith | Daughter | 25 | Female | White | | | | | |
| William Smith | Son | 20 | Male | White | | | | | |
| Anna Smith | Daughter | 15 | Female | White | | | | | |
| Thomas Smith | Son | 10 | Male | White | | | | | |
| John Smith | Son | 5 | Male | White | | | | | |

Witness my hand and seal of the probate court of the County of [blank], State of [blank], on the [blank] day of [blank], 19[blank].

[Signature]

Notary Public for the County of [blank], State of [blank].

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 3 8 8

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|---------------------|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leoma Iva Cook | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 6, 1981 | | 2b. HOUR
2:41p M | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 18, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chrysler Corp. Office | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Indiana | | 13b. COUNTY
Vigo | | 13c. CITY OR TOWN
Terre Haute | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2025 231/2 Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Calvin Wright | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Costello | | | | 16. ADDRESS
2205 Agenturine Lane S.S.Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
None | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
383 09 0046 | | 17. INFORMANT
Betty Marcian (Daughter) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Cardiopulmonary shock</u>
(c) <u>Arterio myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/6 24h
1/5 | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>none</u> | |
| 19a. DATE OF OPERATION
<u>0</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>0</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>N/A</u> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>N/A</u> 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
<u>0</u> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/>
<u>N/A</u> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>N/A</u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u>N/A</u> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>81</u> , to <u>1/6</u> , 19 <u>81</u> , that (I) (we) lost
saw the deceased alive on <u>1/6</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/6/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Schoengold | | | | 22e. ADDRESS
18111 Pr. Philip Dr. Olney, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY
High Land Lawn | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Terre Haute Vigo Indiana | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md. | | | | 25. DATE RECEIVED BY REGISTRAR
JAN 9 1981 | | | | 26. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

M

52

69

52

017

3

MEDICAL CERTIFICATION

2

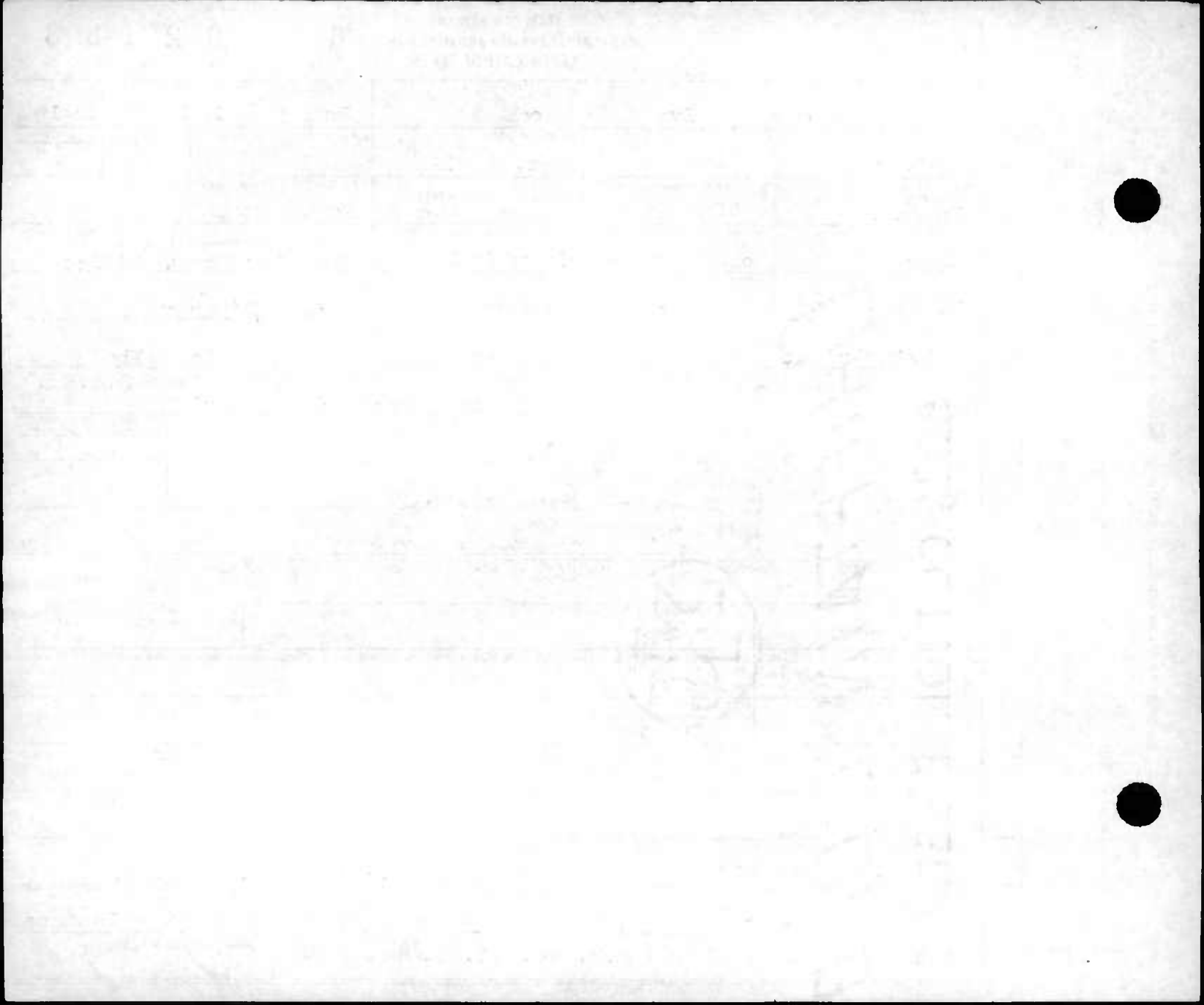
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

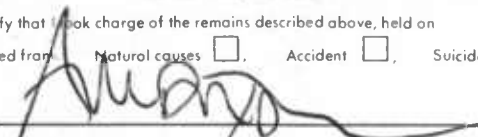
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 0 2 3 8 9 | |
|---|--|------------------------------|--|---|--|---|--|--|---------------------------|--|--|
| 1- FOR REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WILLIAM C. COOK, JR. | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
1 26 1981 | | 2b. HOUR
4:55 a | | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 4, 1955 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
25 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
1 26 1981 | | 7d. HOUR
4:55 a | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18810 Chandlee Mill Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William C. Cook, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frances V. Stevenson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
212-64-1557 | | | | 17. INFORMANT ADDRESS
Frances Hall (Mother) same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound to lower abdomen & thighs
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 9651
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MINUTE MONTH DAY YEAR
2 P.M. 1-25- 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Shot during argument. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
woods | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
Chandler Rd., Sandy Spring, Montgomery Md. | | | | | |
| 22a. I certify that took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-26-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-30-81 | | 23c. NAME OF CEMETERY OR CREMATORY Johnsville Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Johnsville, Howard, Md. | | | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | ADDRESS 246 N. Washington Street Rockville, Md. 20850 | | | | 25a. DATE RECD. BY REGISTRAR JAN 30 1981 | | | |

anyone
U.S.A.
Truck driver

Mr. J. J. Jones
London
William C. Cook, Jr.
Franklin D. Roosevelt
111-11-1007
Franklin D. Roosevelt (former) same as 111-11-1007

George W. Thompson
Rockville, Md. 20850
1-30-11
Thompson
500 I. Washington Street
JAN 10 1961
Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 81 02390 | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
John J. COONEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 21 1981 | | 2b. HOUR
11:17 ^{PM} | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 24 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
50 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | | 7b. HOUR
11:17 ^{PM} | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY
Maryland Pr. George | | | | 13b. CITY OR TOWN
Seabrook | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9616 Van Buren Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Vincent Cooney | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Madeline Forlough | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO. (1944-68)
1948-68 | | 17. INFORMANT ADDRESS
Mrs. Marilyn T. Cooney See item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ruptured esophageal varices complicating cirrhosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the decedent from Jan. 2 1981, to Jan. 21 1981, that (I) (we) lost
saw the deceased alive on Jan. 21 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Mitchell Fink</i> DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
Jan. 23 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mitchell FINK, M.D. | | | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
26 JAN 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | | | |
| 24. FUNERAL DIRECTOR NAME
Lou Grant Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Robert H. B...</i> | | | |

0405 BP

RECEIVED
JAN 30 1961

20 JAN 1961

RECEIVED

JAN 30 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02391

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PATRICIA ANN COOPER | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 18 1981 | | 2b. HOUR
3:30 PM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
May 3 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., DC | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wash. Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Bowie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Grim | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Irene Pace | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO
215-38-6170 | | 17. INFORMANT
ADDRESS
Douglas C. Cooper (above address) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
5580 IMMEDIATE CAUSE (a) Acute Electrolyte Imbalance
DUE TO, OR AS A CONSEQUENCE OF
(b) DIARRHEA, severe
DUE TO, OR AS A CONSEQUENCE OF
(c) -
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
1 week | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
MUSCULAR DYSTROPHY WITH PULMONARY & CARDIAC FAILURE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 16, 1980 to JAN 18, 1981 , that (I) (we) last saw the deceased alive on JAN 18, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert Gerwin M.D. DEGREE MD | | | | 22c. DATE SIGNED
1-18-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Gerwin, M.D. | | | | 22e. ADDRESS
6525 Belcrest Rd, Hyattsville, Md 20782 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/21/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | | 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. | | 25. DATE REC'D. BY REGISTRAR
JAN 26 1981 | |
| 25b. REGISTRAR'S SIGNATURE
Hester McCreedy | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 3 9 2 | |
|--|--|---|--|---|--|--|--|--|--|---------------|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Belle Corbett</i> | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>11/20/81</i> | | 2b. HOUR
<i>4¹⁵ AM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Aug 15 1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<i>87</i> | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Hebrew Home</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | | | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montg'y</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>6121 Montrose Rd</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>unk unk A Below</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>unk unk unk</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>E. Manning Rabin</i> | | ADDRESS
<i>5805 Midhills St Bethesda Md</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CEREBRAL INFARCTS</i>
<i>4340</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>CEREBRAL THROMBOSES</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>—</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 DAYS</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>DEMENTIA</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>9/26/1979</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/26/1979</i> , to <i>1/20/1981</i> , that (I) (we) lost
saw the deceased alive on <i>1/20/1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>A. Patel</i> | | | | DEGREE
<i>M.D.</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>11/20/81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>D. D. PATEL</i> | | | | 22e. ADDRESS
<i>6121 MONTROSE RD, Rockville Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>JAN 28 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>King David Memorial Falls Church Fairfax Va</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>W. H. Chambers</i> | | ADDRESS
<i>Silver Spring Md</i> | | 25. DATE REC'D. BY REGISTRAR
<i>JAN 26 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCreedy</i> | | | | | |



UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

Bellevue

February 12, 1911

My dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours very truly,

John D. Long

Secretary of Agriculture

Washington, D. C.

Very truly,
John D. Long

Secretary of Agriculture

Washington, D. C.

Enclosed for you are two copies of the report of the

Commissioner of the General Land Office, dated January 10, 1911,

relative to the proposed sale of the lands of the

United States in the State of Texas.

I am, Sir, very respectfully,
Yours very truly,

John D. Long

Secretary of Agriculture

Washington, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02393 | |
|---|--|--|--|---|--|---|--|---|-----|--|--|
| 1. FOR
1- STATE
REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Gerald - Corning | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1.28.1981 | | 2b. HOUR OF DEATH 5:04 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR Sept. 2, 1914 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 66 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1.28.1981 | | 2d. HOUR 5:04 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | | MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Educator | | 12b. KIND OF BUSINESS OR INDUSTRY
University | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10420 Burnt Ember Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bernard - Corning | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bess - Kramer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
133-07-5414A | | 17. INFORMANT
ADDRESS
Helen Corning (Wife) Same as # 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4110 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Cardio Vascular Disease -
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball | | | | TITLE (SPECIFY)
M.D. DePoty | | | | MEDICAL EXAMINER
DATE SIGNED Jan 28, 1981 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) DR. JOHN G. BALL, M.D. | | | | ADDRESS Silver Spring, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | | | 23b. DATE
Jan/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, P.G. Co., Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chambers Funeral Home Silver Spring, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
Barney McQuinn | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 9 4

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|--|-----------------------------|--|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mario Michael Costantini | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-19-81 | | 2b. HOUR
11:10 AM | | | | | | |
| 3 SEX
Male. | | 4 RACE
White. | | 5 DATE OF BIRTH
MONTH DAY YEAR
August 15, 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | # UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | # UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Federal Government | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
IN STATE IN COUNTY
Maryland. Prince Geo. Hyattsville | | | | | | 13b. CITY OR TOWN
Hyattsville | | 13c. STREET ADDRESS
5402 14 th. Ave. Hyattsville | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Fred Costantini. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cristina Cecchini | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | 17 INFORMANT ADDRESS
Marian T. Costantini (Wife) 13 e. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation
2030
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Multiple myeloma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year.
1 year. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 1980 , to January 17, 1981 , that (I) (we) last saw the deceased alive on January 16, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Keith M. Lindgren | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/19/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Keith M. Lindgren | | | 22e. ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial. | | | 23b. DATE
Jan. 22, 1981 | | | 23c. NAME OF CEMETERY OR CREMATORY
Gate Of Heaven | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montg. | | |
| 24. FUNERAL DIRECTOR
NAME
Arthur Kellers | | | 25. FUNERAL HOME
Takoma Funeral Home Inc. | | | 26. DATE RECEIVED BY REGISTRAR
JAN 22 1981 | | | 27. REGISTRAR'S SIGNATURE
[Signature] | | |
| 28. ADDRESS
254 Carroll St. N. W. D. C. | | | | | | | | | | | |

BP

DHMH-16 25M
(VRA 15, 4) 1/79

11:10 AM

1-19-61

Costantino

Michael

Mario

Mont.

Washington Adventist Hospital

Prince George's County, Maryland

Prince George's County

Prince George's County

Prince George's County

Prince George's County

Prince George's County (1961) 15 p.

10.

Prince George's County (1961) 15 p.

Prince George's County (1961) 15 p.

Prince George's County (1961) 15 p.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02395

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------------------|---|--|--|---------------------|---|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>William Charles Cramer</i> | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <i>Jan 2 1981</i> | | | 2b. HOUR
<i>9 P</i> | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Mar 15 19 61</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY
<i>61 YRS.</i> | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD
<i>Jan 6 1981</i> | 10. HOUR
<i>10 P</i> | |
| 11. BIRTHPLACE (STATE OR TERRITORY)
<i>PENNSYLVANIA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | |
| 15. CITY OR TOWN OF DEATH
<i>Tak. Park</i> | | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>8210 Greenwood Ave Apt 3</i> | | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>FARMER</i> | | 18. KIND OF BUSINESS OR INDUSTRY
<i>FARM</i> | | |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
19a. STATE
<i>MD</i> | | 19b. CITY OR TOWN
<i>Mont. Tak Park</i> | | 19c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 19d. STREET ADDRESS
<i>8210 Greenwood Ave Apt 3</i> | | |
| 20. FATHER'S NAME
FIRST MIDDLE LAST
<i>DAVID CRAMER</i> | | 21. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>RACHEL MAE CLAWSON</i> | | 22. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | 23. SOCIAL SECURITY NO.
<i>211-12-9092</i> | | |
| 24. INFORMANT
<i>JOANNE C. CAPLES-KENSINGTON, MD</i> | | 25. ADDRESS
<i>10104 THORNWOOD RD</i> | | 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Diabetes</i>
2500
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<i>None</i> | | | | | | | | |
| 27a. DATE OF OPERATION
<i>None</i> | | 27b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 28. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 29a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 29b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 30a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 30c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 31. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| 32. ACTUAL SIGNATURE
<i>John S. Rogers</i> | | 33. TITLE (SPECIFY)
<i>Dep</i> | | 34. MEDICAL EXAMINER
<i>JOHN S. ROGERS</i> | | 35. DATE SIGNED
<i>Jan. 6 1981</i> | | |
| 36. EXAMINER'S NAME (TYPE OR PRINT)
<i>JOHN S. ROGERS</i> | | 37. ADDRESS
<i>1919 SEMINARY RD. S.S. MD.</i> | | 38. DATE REC'D. BY REGISTRAR
<i>JAN 14 1981</i> | | | | |
| 39. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>CREMATION</i> | | 40. DATE
<i>1/7/81</i> | | 41. NAME OF CEMETERY OR CREMATORY
<i>CEDAR HILL CREM-</i> | | 42. LOCATION
CITY OR TOWN COUNTY STATE
<i>SUITLAND - P.G. MD</i> | | |
| 43. FUNERAL DIRECTOR
NAME
<i>W.W. CHAMBERS CO.</i> | | 44. ADDRESS
<i>SILVERSPRING MARYLAND</i> | | 45. DATE REC'D. BY REGISTRAR
<i>JAN 14 1981</i> | | | | |

1978 January 10 2.2 PM
1978 January 10 2.2 PM
1978 January 10 2.2 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 1 0 2 3 9 6 | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gladys L Crosse | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-5-81 | | | | 2b. HOUR
10²⁹ A.M. | |
| 3. SEX
Female | | 4. RACE
Jamaican | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 4 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Jamaica | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
JAKOMA PK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8618 11th. Avenue | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Wilson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Thompson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
563-88-1015 | | 17. INFORMANT (Son)
Wycliffe G. Crosse | | ADDRESS 5614 62nd. Avenue Riverdale, Md. 20840 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) coronary artery aneurysm
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
thrombocytopenia + glomerulonephritis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15/81 to 1/5/81 , that (we) last saw the deceased alive on 1/5/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Lewis H. Dennis | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/6/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Lewis H. Dennis | | | | 22e. ADDRESS
831 University Blvd. E., Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 9, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | | | ADDRESS
11800 N.H. Ave. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

with a view to the

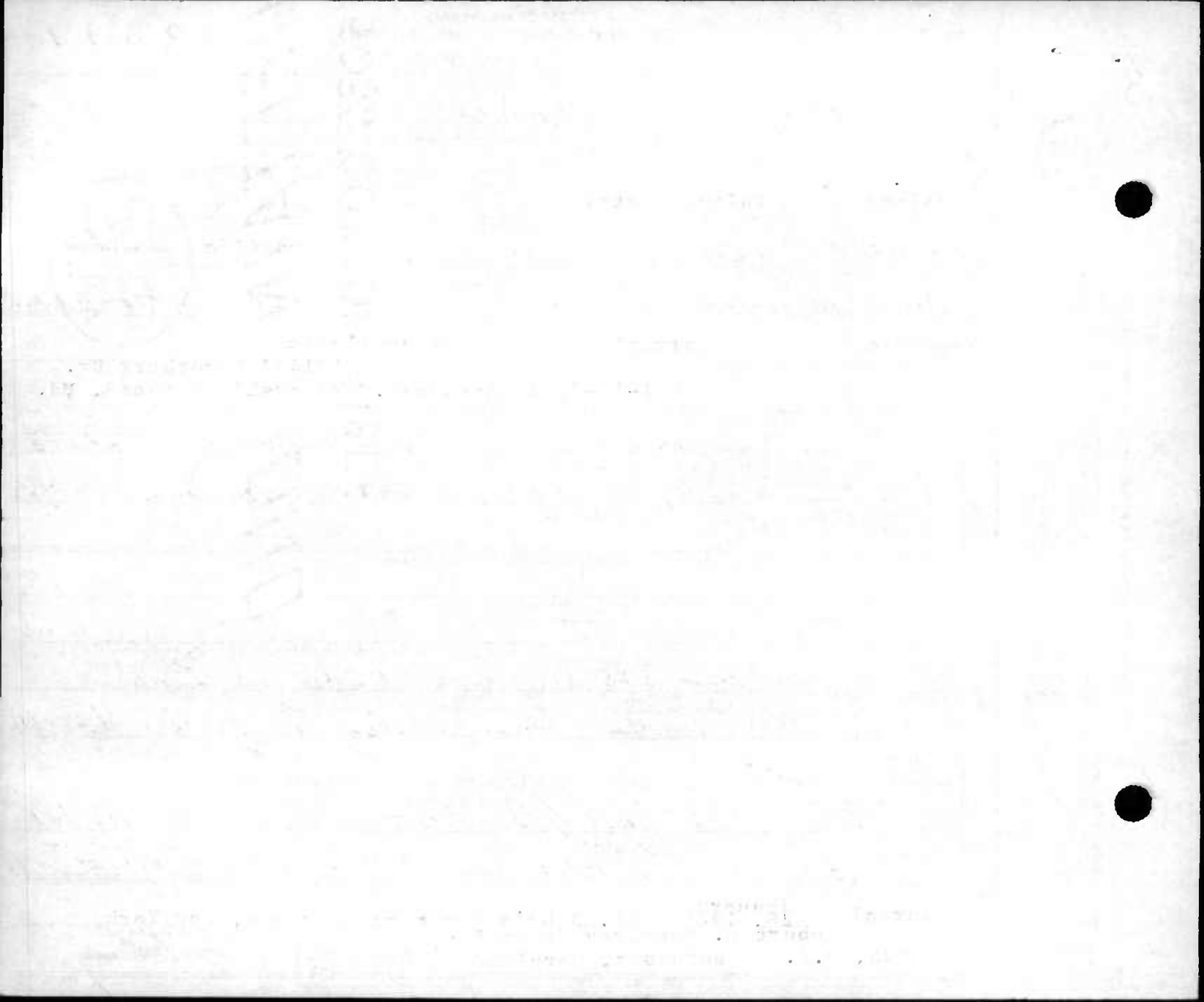
the same

the same

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02397 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARY CZAJKOWSKI | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 1 25 19 81 | |
| 3. SEX Fe 4. RACE CAUC 5. DATE OF BIRTH
MONTH 3 DAY 15 YEAR 90 6. AGE (IN YEARS)
LAST BIRTHDAY 90 YRS. 7c. DATE PRONOUNCED DEAD
MONTH 1 DAY 25 YEAR 19 81 | | | | | | | | | | 7b. HOUR A M 7d. HOUR 2 35 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland 7b. CITIZEN OF WHAT COUNTRY? United States 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4521 EAST WEST HIGHWAY | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING) Housewife 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN BETHESDA 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 4521 EAST WEST HIGHWAY | |
| 14. FATHER'S NAME
FIRST Theodore MIDDLE Karyszin LAST Karyszin | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Not available MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 081-12-5781D | | | | | | | | | | 17. INFORMANT 4310 Kentbury Dr. Anthony F. Czajkowski Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
10-15 YRS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Asym 125 1981 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
FIND DEAD IN BED | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK HOME | | | | | | | | | | 21f. LOCATION
STREET 4521 EAST WEST HIGHWAY CITY OR TOWN BETHESDA COUNTY MONTGOMERY STATE MD | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle M.D. TITLE (SPECIFY) Dept | | | | | | | | | | DATE SIGNED 1/25/81 | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE ADDRESS 8200 Wisconsin Ave Bethesda, Md | | | | | | | | | | MEDICAL EXAMINER | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 28 January 1981 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Homes, P.A. Bethesda, Maryland | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1981 25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may, be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared with MED EXAM. (MAYLO)

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 3 9 8

REG. NO.

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ALLIE V. DEAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 10, 1981 | | 2b. HOUR
8:00A M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 25, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co., MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7918 Rocky Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
7918 Rocky Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Flo - Morris | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada - Geer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
227-28-9688 | | 17. INFORMANT
ADDRESS
Bernice O. Collins, Item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL DISEASE - TERM.
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROSIS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ORGANIC BRAIN SYNDROME | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED:
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from MAY 30 1977 to JAN 10 1981 that (2) the last saw the deceased alive on 9/24/80 , and that in my opinion death occurred on the date and hour and from the causes stated above. (We (I) (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE
Donald R. Lewis | | DEGREE
MD | | 22c. DATE SIGNED
1/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. R. LEWIS MD | | 22e. ADDRESS
OLNEY, MD 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
Jan. 12, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE
Barbara M. Brady | |

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/10/01 BY 60322

10/10/01

10/10/01

10/10/01

10/10/01

10/10/01

10/10/01

10/10/01

[Faint, mostly illegible handwritten notes and markings, possibly including a signature and date.]

10/10/01

5200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 81 02399 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ROBERT R. DE MAIO | | | | 2a. DATE OF DEATH MONTH DAY YEAR
11/29/81 | | | |
| 3. SEX M | | | | 2b. HOUR 4:20A M | | | |
| 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR
11 - 2 - 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Cherry Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7420 Western Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Builder | | 12b. KIND OF BUSINESS OR INDUSTRY
Building | |
| 13a. STATE Md | | | | 13b. COUNTY Montgomery | | | |
| 13c. CITY OR TOWN
Cherry Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7420 Western Ave, Cherry Chase | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
VINCENTO R. DEMAYO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
THERESA I. RISCITILLO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW-11 | | 17. INFORMANT (wife) ESTELLE DEMAYO 7420 Western Ave, Cherry Chase | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Respiratory failure</u>
3353
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory paralysis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Amyotrophic lateral sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hr.
2 hr.
32 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
None. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>69</u> , to <u>January 29</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>January 29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Ralph F. Patten MD</u> DEGREE <u>MD</u> | | | | 22c. DATE SIGNED
1/29/81 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RALPH F. PATTEN MD | | | | 22e. ADDRESS
1407 Woodlark Parkway Silver Spring MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-31-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Sil. Spring Montgomery Md. | |
| 24. FUNERAL DIRECTOR
Walter E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md. | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 0 0

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SUCHA S. DHILLON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 16, 1981 | | 2b. HOUR
2:30 PM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
December 15, 1989 | 6. AGE (IN YEARS LAST BIRTHDAY)
91 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
India | 7b. CITIZEN OF WHAT COUNTRY?
India | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6401 Winnepeg Rd. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Civil Service | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't. of India | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Amrik S. Dhillion | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not Available | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
Not available | | 17. INFORMANT
ADDRESS
Maram P.S. Dhillion Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIO SCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) 3 YRS. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 m. y |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 16 , 19 81 , to JAN 16 , 19 81 , that (I) (we) lost
saw the deceased alive on Jan 16 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Saul Zukerman MD | | DEGREE
MD | | 22c. DATE SIGNED
1-16-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Saul Zukerman | | 22e. ADDRESS
Washington, D.C.
5410 Connecticut Ave., N.W. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
January 19, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | | |

94411 101103%06

Handwritten notes and stamps, including "RECEIVED" and "JAN 2 1944".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1345.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 0 1

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGARET L. DICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-11-81 | | | 2b. HOUR
4:45 PM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-27-1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew Robinson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susan P. Zimmerman | | | 16. STREET ADDRESS
8853 Wendy Lane | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT (dau) 709 Tanley Road,
Ruth B. Lacey-Silver Spring, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastasis
DUE TO, OR AS A CONSEQUENCE OF:
(b) To liver and vena cava
DUE TO, OR AS A CONSEQUENCE OF:
(c) 1579 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes mellitus; arteriosclerotic heart disease | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/9 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Diabetes mellitus; arteriosclerotic heart disease | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from January 1979 to January 11, 1981 , that (I) (we) last saw the deceased alive on January 10, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Aaron H. Traum | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
January 11, 1981 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AARON H. TRAUM MD | | | 22e. ADDRESS
8415 Georgia Ave Silver Spring, Md 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1-14-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Burtonsville Union | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Burtonsville Montg. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Pumphrey, Inc | | | | | ADDRESS
8434 Ga. Ave., S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

12

THE UNIVERSITY OF CHICAGO
LIBRARY

UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16-30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02402

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph DiFiore | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan 9 '81 | | 2b. HOUR
MIN.
7:30 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 25, 1896 | 6. AGE
(IN YEARS LAST BIRTHDAY)
84 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ITALY | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Seabury Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
MASON |
| 13a. STATE
MD. | | | 13b. COUNTY
Howard | 13c. CITY OR TOWN
Fulton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph DiFiore | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Azzavone | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
151-05-0844 | | |
| 17. INFORMANT
ADDRESS
Elizabeth Kotting 8491 Reservoir Rd
Fulton, MD | | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 WEEK |
| 4360
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Atherosclerosis | | 3 YEARS |
| (c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from July 19 79 to 1/9 81 , that (I) (we) lost
saw the deceased alive on 1/8 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (We) (I) did (did not) view the body after death. | | | |
| 22b. SIGNATURE
Thomas G. Ward MD | | DEGREE
MD | 22c. DATE SIGNED
1/9/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS G. WARD MD | | 22e. ADDRESS
6116 ROBINWOOD, Bethesda, MD | |

| | | | |
|--|-----------------------------------|---|--|
| 23a. BURIAL CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
JAN. 12, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery MD |
| 24. FUNERAL DIRECTOR
NAME
H. J. Eckhardt | | ADDRESS
Owings Mills, Md | |

JAN 12 1981

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Margaret W. Dillon | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 17, 1981 | | | 2b. HOUR
4:55 P
M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 21, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
City of New York | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4601 N. Park Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Otto Pelz | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret E. Heller | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
144-03-2278 | | 17. INFORMANT
Margaret K. Coffey | | ADDRESS
Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Disease
4292
DUE TO, OR AS A CONSEQUENCE OF dissecting aortic aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/17/79 19 77 , to 1/17 19 81 , that (I) (we) last saw the deceased alive on 1/17/81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
Myron L. Lenkin MD | | | | | | 22b. DEGREE
MD | | 22c. DATE SIGNED
January 17, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Myron L. Lenkin | | | | | | 22e. ADDRESS
2309 Shorefield Road
Wheaton, Maryland 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
January 20, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL
HOMES, P.A., Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

1981

January 19, 1981

Bill

Dear Bill

January 20, 1981

Dear Bill

Thank you for the letter of January 19, 1981.

I am sorry that I cannot give you a more definitive answer at this time.

I will be sure to let you know as soon as I have a final decision.

Sincerely,

John A. [Signature]

Director, [Title]

U.S. Department of [Agency]

Washington, D.C. 20540

Enclosed for you are [Number] copies of [Document]

I am sure you will find this information helpful.

Very truly yours,

John A. [Signature]

Director, [Title]

U.S. Department of [Agency]

Washington, D.C. 20540

Enclosed for you are [Number] copies of [Document]

I am sure you will find this information helpful.

Very truly yours,

John A. [Signature]

Director, [Title]

U.S. Department of [Agency]

Washington, D.C. 20540

January 21, 1981

John A. [Signature]

John A. [Signature]

U.S. Department of [Agency]

[Signature]

JAN 22 1981

U.S. Department of [Agency]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE DEATH CERTIFICATE, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH: 17
(VR 15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02404

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM J. DOUGHERTY | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 1/31/1981 | | | 2b. HOUR 8:15 AM | | |
| 3. SEX
MALE | 4. RACE
CAUC | 5. DATE OF BIRTH
MONTH 9 DAY 13 YEAR 92 | 6. AGE (IN YEARS)
LAST BIRTHDAY 88 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
MONTH 1 DAY 31 YEAR 1981 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONT GOMERY MD | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WEST WOOD RETIREMENT HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Interior Depart. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
DC | 13b. COUNTY
— | 13c. CITY OR TOWN
WASHINGTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3367 STEPHENSON PL. NW | | | |
| 14. FATHER'S NAME
FIRST William MIDDLE — LAST Dougherty | | | | 15. MOTHER'S MAIDEN NAME
FIRST Anna MIDDLE — LAST Quigley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
184-12-3073 | | 17. INFORMANT Son
ADDRESS Robert M. Dougherty Sameas #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL AORTIC ANEURYSM
4413
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) ABDOMINAL ANEURYSM
(c) ARTERIOSCLEROTIC DISEASE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
9 mo
15 YRS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. 1 MONTH 3 DAY 1 YEAR 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FOUND DEAD IN BED | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
NURSING HOME | | 21f. LOCATION
STREET ST. MARY'S FIELD RD CITY OR TOWN BETHESDA COUNTY MONT STATE MD | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayhew Jr. | | | TITLE (SPECIFY)
Dept | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME
(TYPE OR PRINT) FRANCIS C. MAYHEW JR. | | | ADDRESS 8200 Wisconsin Ave. Bethesda MD | | | DATE SIGNED 1/31/81
20014 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
Feb. 3, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN Alexandria, Virginia COUNTY — STATE — | |
| 24. FUNERAL DIRECTOR
NAME DeVol Funeral Home | | | ADDRESS Washington, D.C. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

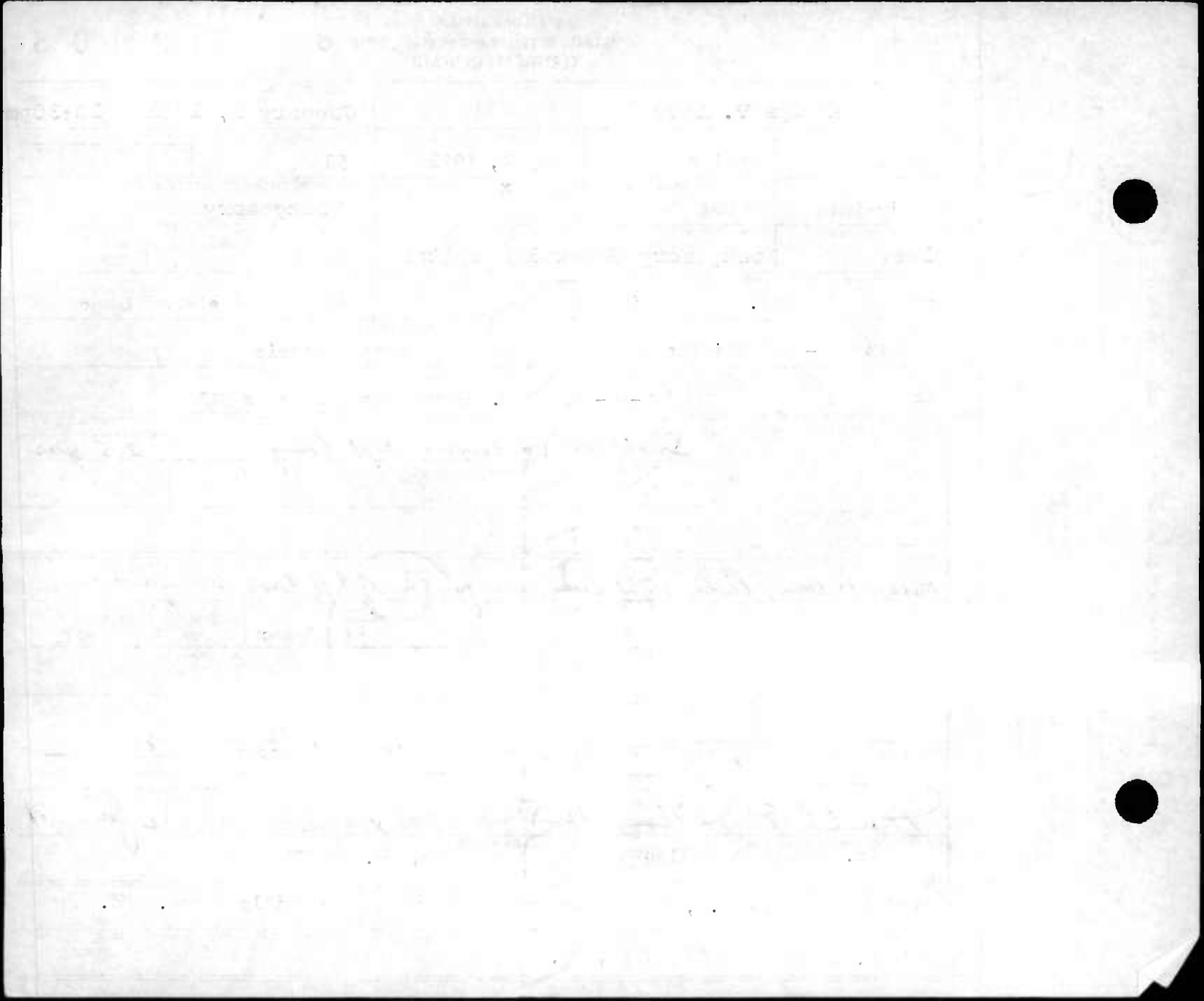
1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

0 2 4 0 5

REG. NO.

| | | | | | | |
|--|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gladys V. Dove | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 1, 1981 | | 2b. HOUR
10:30pm | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 4, 1922 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. AGE (IN YEARS LAST BIRTHDAY)
58
YRS MONTHS DAYS HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sutty - Shifflett | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Anna Morris | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
218-20-2257 | | 17. INFORMANT
ADDRESS
M. Floyd Dove Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Small Cell Carcinoma left lung
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2.5 yrs. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Metas. to Bone, liver, right lung, non-function of left lung, urinary retention, | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 Jan 79 to 1 Jan 81 , that (I) was last saw the deceased alive on 1 Jan 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) was did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Donald E. Dillon MD
DEGREE | | | | 22c. DATE SIGNED
2 Jan 81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Donald E. Dillon | | | | 22e. ADDRESS
Olney, Md. 20832 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 5, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | | |
| 23d. LOCATION
Rockville | | 23e. COUNTY
Mont. | | 23f. STATE
Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS H. BARBER LAYTONSVILLE, MD. 20760 | | | | 25. DATE REC'D. BY REGISTRAR
JAN 5 1981 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Tracy McCready | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Clara N. Downs | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 22 1981 | | | 2b. HOUR
B:15P. M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 11, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5927 Lemay Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
5927 Lemay Road | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John T. Gordy | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Hall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-16-0252 | | 17. INFORMANT
ADDRESS
James R. Downs (Same as 13e) | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus, feeding</u>
<u>1749</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of Breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 mos</u>
<u>2/79</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Hypertension</u> | | | | | | | |
| 19a. DATE OF OPERATION
<u>2/9</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Hypertension</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/8/85</u> 19 <u>85</u> to <u>1/22/81</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>10/4/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Stephen N. Jones, M.D.</u> | | DEGREE
JONES, M.D., F.A.C.P.
ATTENDING MEDICAL STAFF
DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>
22c. DATE SIGNED
<u>1/23/81</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen N. Jones, M. D. | |
| 22e. ADDRESS
800 Viers Mill Road
Rockville, MD. 20851
762-5010 | | 22f. ADDRESS
809 Viers Mill Road
Rockville, Maryland 20851 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
Jan. 27, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Monocacy Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Beallsville Maryland | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY
P. A., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a list or a report, spanning the majority of the page.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 0 7

FOR
1- STATE
REGISTRAR

REG. NO.

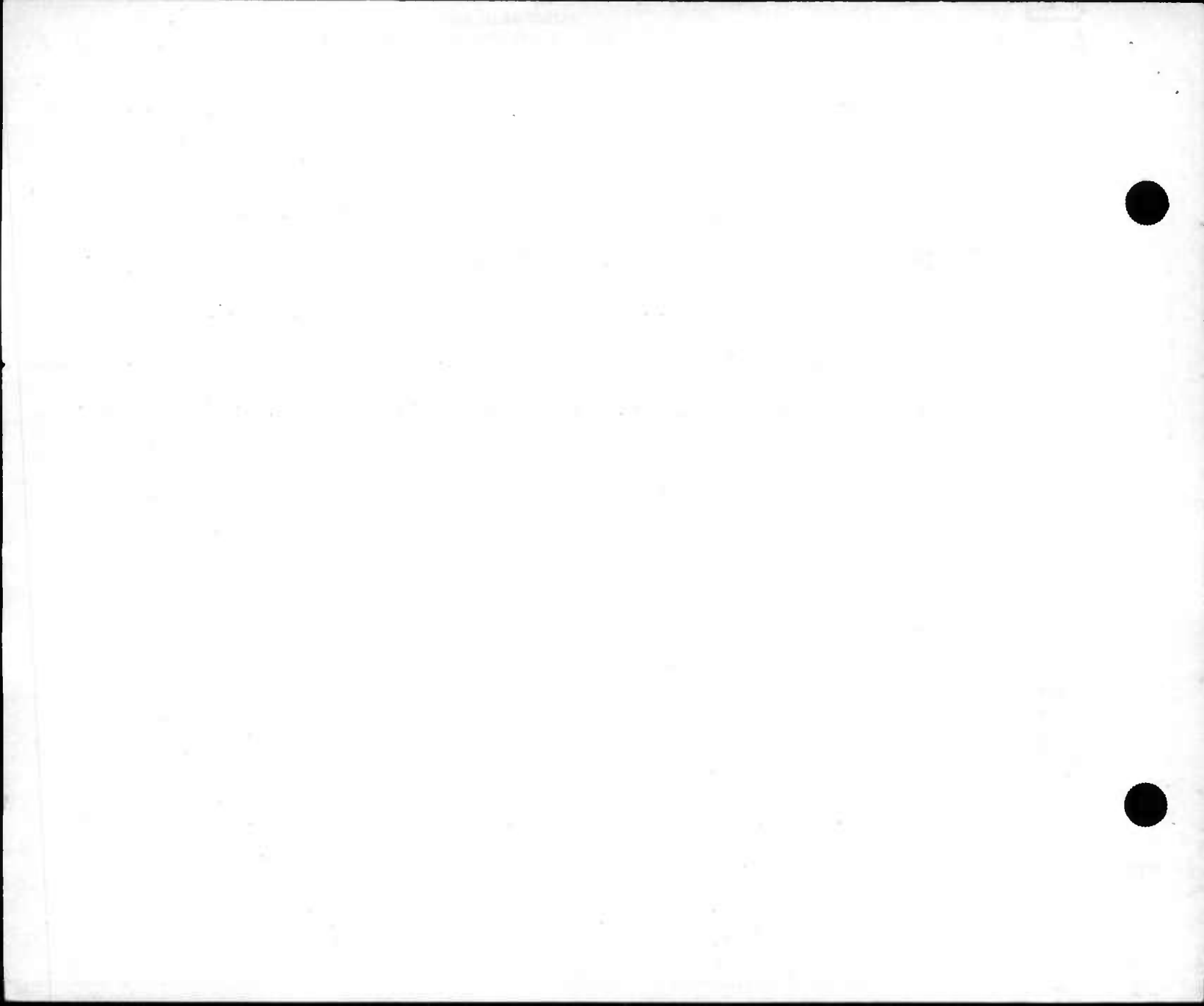
| | | | | | | |
|---|--|--|--|---|---------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
John Reed Dull, JR. | | | 2a DATE OF DEATH MONTH DAY YEAR
1/18/81 | | 2b HOUR
2:55 AM | |
| 3 SEX
MALE | 4 RACE
WHITE | 5 DATE OF BIRTH
MONTH DAY YEAR
MAY 8, 1929 | 6 AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D. C. | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Silver Spring Hosp | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ELECTRONICS TECH | 12b KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b STATE
MARYLAND | | | 13c CITY OR TOWN
SILVER SPRING | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
JOHN R. DULL, SR. | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROBERTA TOLLEY | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b SOCIAL SECURITY NO.
579-42-4325 | | 17 INFORMANT
MARY H. DULL | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1534
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Renal tubular necrosis 2° to surgery
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma colon with extensive liver metastases | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days
12 days
3 months | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a DATE OF OPERATION
1/6/81 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer Colon - liver metastases | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/18 19 81 to 1/18 19 81 , that (I) (we) last saw the deceased alive on 1/18 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE
J. R. Thistlethwaite | | DEGREE
M.D. | | 22c DATE SIGNED
1/19/81 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
J. R. Thistlethwaite | | 22e ADDRESS
10401 Old Georgetown Rd BETH. | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b DATE
1/21/81 | | 23c NAME OF CEMETERY OR CREMATORY
FT. LINCOLN | | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PRI GEO MD. | | 24 FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | |
| 25a DATE REC'D. BY REGISTRAR
JAN 22 1981 | | 25b REGISTRAR'S SIGNATURE
Robert M. Bueh | | | | |

47 70 38 56 1
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Examined by Dr. Mayles, Medical

Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at once).

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 0 8

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Katherine Norris DUVALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 8, 1981 | | 2b. HOUR
2:30A_M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 26, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co., MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
16504 Walnut Hill Rd. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
16504 Walnut Hill Rd. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George A. Alexander | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Leahy | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-16-3937 | | 17. INFORMANT ADDRESS
R. Preston Duvall, Item 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma (L) Breast
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Brain, liver, retroperitoneal, retinal, bone metastasis. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 77 , to 8 Jan , 19 81 , that (I) was last saw the deceased alive on 5 Jan , 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Donald E. Dillon MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Jan. 8, 1981 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | | | 22e. ADDRESS
18111 Prince Philip Dr., Olney, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 10, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Damascus Meth. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Damascus, Montgomery, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., | | | | ADDRESS
Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | | REGISTRAR'S SIGNATURE
<i>Richard M. ...</i> | |

7048 BP

1931

January 1, 1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 0 9
REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME | | | |
| FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| EVA ELIZABETH EARP | | | | 1. 10.31.51 | | | |
| 3. SEX | | | | 4. RACE | | | |
| Female | | | | White | | | |
| 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| MONTH DAY YEAR | | | | YRS. MONTHS DAYS HOURS MIN. | | | |
| 08 02 1913 | | | | 67 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | |
| Virginia | | | | USA | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | |
| Rockville | | | | Dollinger Nursing Center | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Housewife | | | | Home | | | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| Maryland | | | | Montgomery | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| Walter Gaylor | | | | Ella Mae Hayslett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| No | | | | None | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| John W. Earp | | | | 417 Muddy Branch Road Apt T-2 Gaithersburg, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | |
| 5188 | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| Chronic bronchitis, emphysema, pulmonary insufficiency | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | | | | |
| 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | |
| | | | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | (AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION | | | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | | | to | | | |
| above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | |
| Robert H. Birshbach | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22c. DATE SIGNED | | | |
| BIRSCHBACH | | | | 1/10/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | |
| Burial | | | | 1/12/81 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Neelsville Ch. Cem. | | | | Neelsville Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| NAME ADDRESS | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home, Inc., 1331 Rockville Pike Rockville, Maryland | | | | JAN 14 1981 | | | |

823 First Street

x

Mobile

Alabama

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

Robert H. Sikes

1901

1901

1901

1901

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 1 0 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST
Nils Nils Enger | | | | MONTH DAY YEAR
1-15-81 | | | |
| 3. SEX | | | | 2b. HOUR | | | |
| Male | | | | 11:05 AM | | | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| White | | MONTH DAY YEAR
Mar. 1 1903 | | 77 YRS. | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Norway | | U.S.A. | | Montgomery County, MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Suburban Hospital | | Marine Eng. | | Merchant | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Mont. Rockville | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)
Hans Enger | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Kristine Moester | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW1 | | | | 16b. SOCIAL SECURITY NO. Unknown | | | |
| 17. INFORMANT Son | | | | ADDRESS Md. Norman A Enger, 11904 Tallwood Ct., Potomac | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: ACUTE RESPIRATORY INSUFFICIENCY
IMMEDIATE CAUSE (a) 4920
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMPHYSEMA
(c) CONGESTIVE HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks
15 yrs
2 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ARTERIOCLEROTIC HEART DISEASE; CIRRHOSIS OF LIVER | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 10 19 81 to JAN 15 19 81, that (I) (we) last saw the deceased alive on JAN 14 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John B. Nason, MD | | | | DEGREE | | 22c. DATE SIGNED JAN 15, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN B. NASON, MD | | | | 22e. ADDRESS 800 PERSHING DR. SILVER SPRING, MD. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Cremation | | 1/16/1981 | | Cedar Hill Crematory | | Suitland, Maryland | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc 5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D BY REGISTRAR JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE | |

11/1/61
Cedar
Joseph's Home Inc.
2130 Mac
Ave. N. W.

Analysis, Inc.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 1 1

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Doris Walker Estey | | | 2a. DATE OF DEATH
MONTH 1 DAY 21 YEAR 81 | | | 2b. HOUR
1500 M | | | | | |
| 3 SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH Feb. DAY 17 YEAR 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Broker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Boyd's | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
12520 Deoudes Rd. | | |
| 14. FATHER'S NAME
FIRST Hayden MIDDLE S. LAST Walker | | | | 15. MOTHER'S MAIDEN NAME
FIRST Emma MIDDLE LAST Roberts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
178-22-3078 | | 17. INFORMANT (husband)
David E. Estey | | | ADDRESS
Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART 1. DEATH WAS CAUSED BY:
1749
IMMEDIATE CAUSE (a) Probable Hypercalcemia
DUE TO, OR AS A CONSEQUENCE OF (b) Melanotic Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/7 , 19 81 , to 4/24 , 19 81 , that (I) (the hospital) saw the deceased alive on 4/21 , 19 81 , and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. J. Newman | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/22/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. J. Newman | | | 22e. ADDRESS
11500 Old Georgetown Rd., Bethesda Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1981 Jan. 24 | | 23c. NAME OF CEMETERY OR CREMATORY
Island Pond Cem. | | | 23d. LOCATION
CITY OR TOWN Harwich COUNTY Mass. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Capitol Funeral Service, Fairfax, ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOT FOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

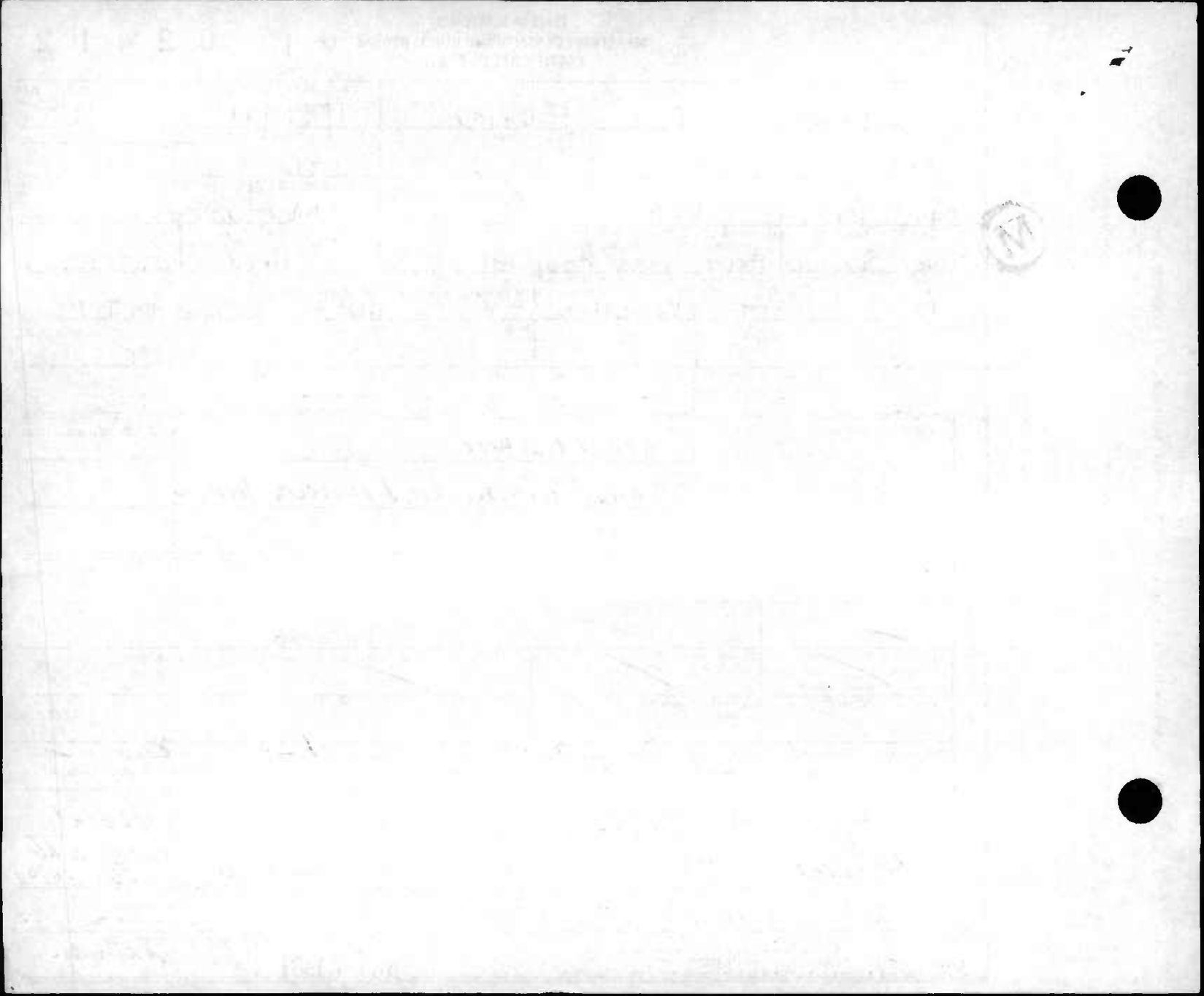
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 1 2

REG. NO.

| | | | | | | | | |
|---|-------------------------------------|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward Dominic Federici | | | 2a. DATE OF DEATH
1/26/81 | | | 2b. HOUR
9:10 AM | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1 12 95 | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVERNMENT | |
| 13a. STATE
MD. | | | 13b. COUNTY
Mont. | | | 13c. CITY OR TOWN
Wheaton | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN FEDERICI | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CARRIE VENTURI | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW I | | | 16b. SOCIAL SECURITY NO.
579-32-0674 | | | 17. INFORMANT
ADDRESS
CATHERINE FEDERICI SAME AS 13 WIFE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure
4292
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27/80 to 1/26/81, that (I) (we) last saw the deceased alive on 1/26/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Raymond Bass | | | DEGREE
MD | | | 22c. DATE SIGNED
1/26/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | | 22e. ADDRESS
16220 FREDERICK AVE 8 Ardmore Subd
MD. 20760 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
SILVER SPRING COUNTY MONT STATE MD. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
JAN 27 1981 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared with Dr. John S. Rogers, Med. Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 1 3 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JULIUS FELDMAN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 21, 1981 | | 2b. HOUR
9:30am | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
Nov. 23, 1923 | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
57 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Program Analyst U.S.C.G. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montg.. Kensington | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3907 Spruell Drive | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Morris Feldman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Bisnow | | 16. ADDRESS
Md. Rose F. Feldman; 3907 Spruell Dr., Kensington | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | 16b. SOCIAL SECURITY NO.
177-14-6406 | | 17 INFORMANT
Rose F. Feldman; 3907 Spruell Dr., Kensington | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
5 Years | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Left Ventricular Aneurysm | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I, the undersigned, attended the deceased from February 19, 80 , to Dec. 29, 1980 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on December 29, 1980 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James O. Rossi MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES A. ROSSI, M.D. | | | | 22e. ADDRESS
6111 Executive Blvd., Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-23-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Maryland | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE OF REGISTRATION
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE | |

9 1 2 5

AMERICAN OVERSEAS
STANDARD TIME



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02414

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|-------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE Grace LAST Filler | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 3, 1981 | | 2b. HOUR 11:40 AM | | |
| 3. SEX female | | 4. RACE caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR Sept. 16, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH Rockville, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home for the Aged | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY at home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Virginia | | 13b. COUNTY Fauquier | | 13c. CITY OR TOWN Warrenton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 404 Jackson Street | | 14. FATHER'S NAME
FIRST Melvin MIDDLE B. LAST Peterson | | 15. MOTHER'S MAIDEN NAME
FIRST Lillian MIDDLE Peacock LAST Peacock | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. 230-84-9232 | | 17. INFORMANT ADDRESS Rev. Richard Reichard 9701 Veirs Dr. P. Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
4140
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1974, to Jan. 3, 1981, that (I) (we) lost the deceased alive on Jan. 3, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Elliott Aleskow MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED 1-3-81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT ALESKOW MD | | 22e. ADDRESS 2141 K Street, N.W. Washington, D.C. | | 22f. DATE REC'D. BY REGISTRAR JAN 14 1981 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 8, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lovettsville, Virginia | |
| 24. FUNERAL DIRECTOR NAME The Hysong Co. ADDRESS 1300 N St. N.W. Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 1 5

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SAKETTA LEVETTE FLEMING | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 1 27 81 | | | | 2b. HOUR
12⁴⁵ AM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 26 81 | | 6. AGE (IN YEARS LAST BIRTHDAY)
0 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 7 3 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
Md | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NA | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. STATE
MD | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
NA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN Fleming | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DIANE T DICKERSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO
--- | | 17. INFORMANT ADDRESS
Benjamin Fleming 8822 Lanier DR. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) severe prematurity - (~16 weeks gest.)
7650
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 26 19 81 to 1 27 19 81 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Jean Rosenthal | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
1/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jean Rosenthal | | | | 22e. ADDRESS
HOLY CROSS HOSP. Silver Spring MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | 23e. DATE FILED BY REGISTRAR
FEB 2 1981 | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc. | | | | 25. ADDRESS
1331 Rockville Pike Rockville, Md. 20852 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

DHMH-16 25M
(VRA 15, 4) 1/79

SMITH LEVETTE FLEMING

Major, 1st Cavalry Division
Silver Star Medal

1931 Rockville, Md. 20852
Green Heeler Funeral Home, Inc.
2/27/71
Late of Heaven Cemetery Silver Spring, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02416

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--------------------------|--|------------------|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR OF ESTIMATED DEATH | | 2c. DATE OF DEATH | | MONTH DAY YEAR | | 2d. HOUR OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR OF ESTIMATED DEATH | |
| Robert Morris Forkish Jr | | | | | | | | Jan 9 1981 | | 19 | | 745 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 21. DATE PRONOUNCED DEAD | |
| M | | W | | April 20 1958 | | 42 YRS. | | MONTHS DAYS | | HOURS MIN | | Jan 9 1981 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Rumania | | USA | | | | Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| P. 1. Spg | | F536 11th Ave | | Med/Tech Retired | | U S Gov't | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Md. | | Montg | | P. 1. Spg | | | | 8036 11th Ave. | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | |
| Irvin Forkish | | | | | | | | Anna Sussman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | WW1 | | 579 28 5598 | | Robert M Forkish Jr | | Falls Church | | Va | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 4291 | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| None | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | | | |
| John G Rogers | | M.D. Dep | | | | Jan 9 1981 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | |
| John G Rogers | | Silver Springs, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | Jan 12, 1981 | | Ft Lincoln Cemetery | | Brentwood Pro Georges Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE FILED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| F. Gasch's Sons | | P A Hyattsville, Md. | | JAN 14 1981 | | | | | | | | | |

[Faint, illegible text, likely bleed-through from the reverse side of the page]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------------|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Victor V. Frediani | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
1/3 1981 | | | 2b. HOUR
M
10:45 A. | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 8, 1919 | 6. AGE (IN YEARS)
LAST BIRTHDAY
61 YRS. | IF UNDER 1 YR.
MONTHS DAYS
0 0 | IF UNDER 24 HRS.
HOURS MIN
0 0 | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1/3 1981 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11011 Madison Street | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Steam Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. STREET ADDRESS
11011 Madison Street | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Frediani | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elena Cherubini | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 578-03-3694 | | 17. INFORMANT ADDRESS
Norma V Frediani Wife. Same as item 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4291
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Carotid body syndrome. | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | TITLE (SPECIFY)
Deputy | | | MEDICAL EXAMINER
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, M.D. | | | ADDRESS | | | DATE SIGNED
1/3/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/8/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland. | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons Inc. | | | | 24b. ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>John S. Rogers</i> | |

BP

DHM-17
(VR A15 ME (5))
15M 7/76

3601

1750 Loc. Ave., N.W., Wash., D.C.
 Joseph Lawler's Sons Inc.
 Date of Heaven's Emery Silver Shrine, Maryland.
 1/8/50

Yes Will 518-05-3894 Norman V. Frediani wife. 4 yrs as item 1.
 George Frediani Glenn Charolain

1.C. U.S.A. Steamship U.S. Gov't.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 1 8

| | | | | | | | | |
|---|--|--|---|--|-----------------------------------|--|--|---------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | | | | |
| Joseph F. Gallagher | | | | | 1 | 12 | 81 | 3 15 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | |
| Male | Cauc | 9 09 18 | | 62 | | YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| PENNSYLVANIA | U.S.A. | | | MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | Holy Cross Hosp. | | SALES REPRESENTATIVE | | GAS CO. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| MARYLAND | | MONTGOMERY | KENSINGTON | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3307 OBERON STREET | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | | | |
| JAMES GALLAGHER | | UNKNOWN | | 17. INFORMANT ADDRESS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| YES | | WW II | | 184-03-5603 RITA I. GALLAGHER SAME AS 13 WIFE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cold</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>79</u> , to <u>1-12</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/12</u> 19 <u>81</u> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I we did not view the body after death.) | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | | |
| Carol Bender | | | | | | 1/13/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | |
| CAROL L. Bender | | | | 11510 Old Georgetown Rd. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| BURIAL | | 1/15/81 | | GATE OF HEAVEN | | SILVER SPRING CITY OR TOWN | | |
| 24. FUNERAL DIRECTOR | | 500. UNIV. BLVD., W. | | SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR | | |
| Francis Collins | | | | | | JAN 16 1981 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 1 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Alfonso NMN Galasso | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-4-81 | | 2b. HOUR
MIN.
7 P. | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 29 1895 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
YRS.
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Tailor | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francesco G. Galasso | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Vencenza M. Romeo | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
069-26-7444 | |
| 17. INFORMANT
ADDRESS
Bethesda, Md. 20014 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure.
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Respiratory Infection ? organism
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Pulmonary Fibrosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
days
years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carcinoma of Lung, Carcinoma of Bladder | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 25 19 80 , to Jan 4 19 81 , that (I) (we) lost saw the deceased alive on Jan 4 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Haris M. Kenner | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HARRIS M KENNER | | | | 22e. ADDRESS
1042 Old Georgetown Rd Bethesda Md 20014 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
ADDRESS
1331 Rockville Pike Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE
Haris M. Kenner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1951 Rockville Pike, Rockville, Maryland
Tyson Wheeler Funeral Home, Inc.

1/7/51

Date of Death January 7, 1951, Silver Spring, Md.

no

--

000-25-9444

Vincent W. Howie 617 Rockmore Dr.

Francisco G.

Calancho

Venezuela

M.

Romeo

Retired, No. 20014

Maryland Montgomery Bethesda

XX

10034 Olive Drive

retired

Tailor

Italy

USA

x

July 29 1952

82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102420

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Gladys Lee Gantz | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 10 81 | | 2b. HOUR
8:20 AM |
| 3. SEX
F | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3 30 08 | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sandy Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | 12b. KIND OF BUSINESS OR INDUSTRY
School | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
401 Russell Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Almony | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Williams | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
313-36-7049A | 17. INFORMANT
ADDRESS
Anne Wood 16633 S. Westland Dr. Gaithersburg | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro-vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 min
3 hrs
1 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Gastroenteritis, Multiple Myeloma</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 7</u> , 19 <u>81</u> , to <u>Jan 10</u> , 19 <u>81</u> , that (II) (we) lost
saw the deceased alive on <u>Jan 10</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (III) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James R. Moore Jr.</u> | | DEGREE
MD | | 22c. DATE SIGNED
1-10-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. MD | | 22e. ADDRESS
207 Brookes Ave Gaithersburg Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1/14/81 | 23c. NAME OF CEMETERY OR CREMATORY
Govans Presbyterian | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Bryce F.H. Gask | | ADDRESS
3631 Falls Rd. | | 25a. DATE REC'D. BY REGISTRAR
JAN 13 1981 | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

PROPERTY OF THE

UNITED STATES

NAVY DEPARTMENT

NAVY DEPARTMENT, WASHINGTON, D. C.

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 2 1

REG. NO.

| | | | | | | | |
|---|--|--|---|--|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Esther VITA Gardner</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>1-12-81</i> | | 2b. HOUR
<i>7:10 PM</i> | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>CAUCASIAN</i> | | 5 DATE OF BIRTH
MONTH DAY YEAR
<i>6-27-22</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>58</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10 CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Shady Grove Adventist Hosp</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
<i>FREELANCE EDITOR</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>BOOKS</i> | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE
<i>JUDAH SHOCHET</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
<i>ETHEL SILVERMAN</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO
<i>N/A</i> | | 17 INFORMANT ADDRESS
<i>ALVIN FREDERICK GARDNER, same as #13</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST (TWICE)</i>
7140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <i>STAPHYLOCOCCUS AUREUS SEPSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>RHEUMATOID ARTHRITIS, SEVERE, WITH DEWBART, multiple</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 DAYS, 35 MINUTES</i>
<i>8 WEEKS</i>
<i>20 YEARS</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<i>MULTIPLE DECBITI, CHRONIC STEROID THERAPY, PROTEIN MALNUTRITION</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>NONE</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>NONE</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>AUGUST</i> , 19 <i>80</i> , to <i>1/12</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/12</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Alan N. Schulman</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1/12/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ALAN N. SCHULMAN, M.D.</i> | | | | 22e. ADDRESS
<i>19291 MONTGOMERY VILLAGE AVE. SUITE H-2, GAITHERSBURG, MD. 20760</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>1/14/1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>MOUNT NEBO CEMETERY</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>MIAMI DADE FLORIDA</i> | |
| 24. FUNERAL DIRECTOR
<i>DR. MORRIS STEIN HEBREW MEMORIAL FUNERAL HOME</i> | | | | 25. DATE REC'D. BY REGISTRAR
<i>1-16-81</i> | | | |
| 26. ADDRESS
<i>232 CARROLL STREET, N. W., WASHINGTON, D. C.</i> | | | | 27. REGISTRAR'S SIGNATURE | | | |

BP

1870

6

RECEIVED
JAN 10 1870
U.S. DEPT. OF AGRICULTURE

...

...

...

...

...

...

...

...

...

...

...

...

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ALDA K. GASKILL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 14, 1981 | | 2b. HOUR
4:40 P |
| 3. SEX
FEMALE | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
June 12, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Germantown | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hickman T. Kelley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Allender Allender | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
265-22-3832 | | 17. INFORMANT
ADDRESS
Leon W. Kelley Same as 13 | |

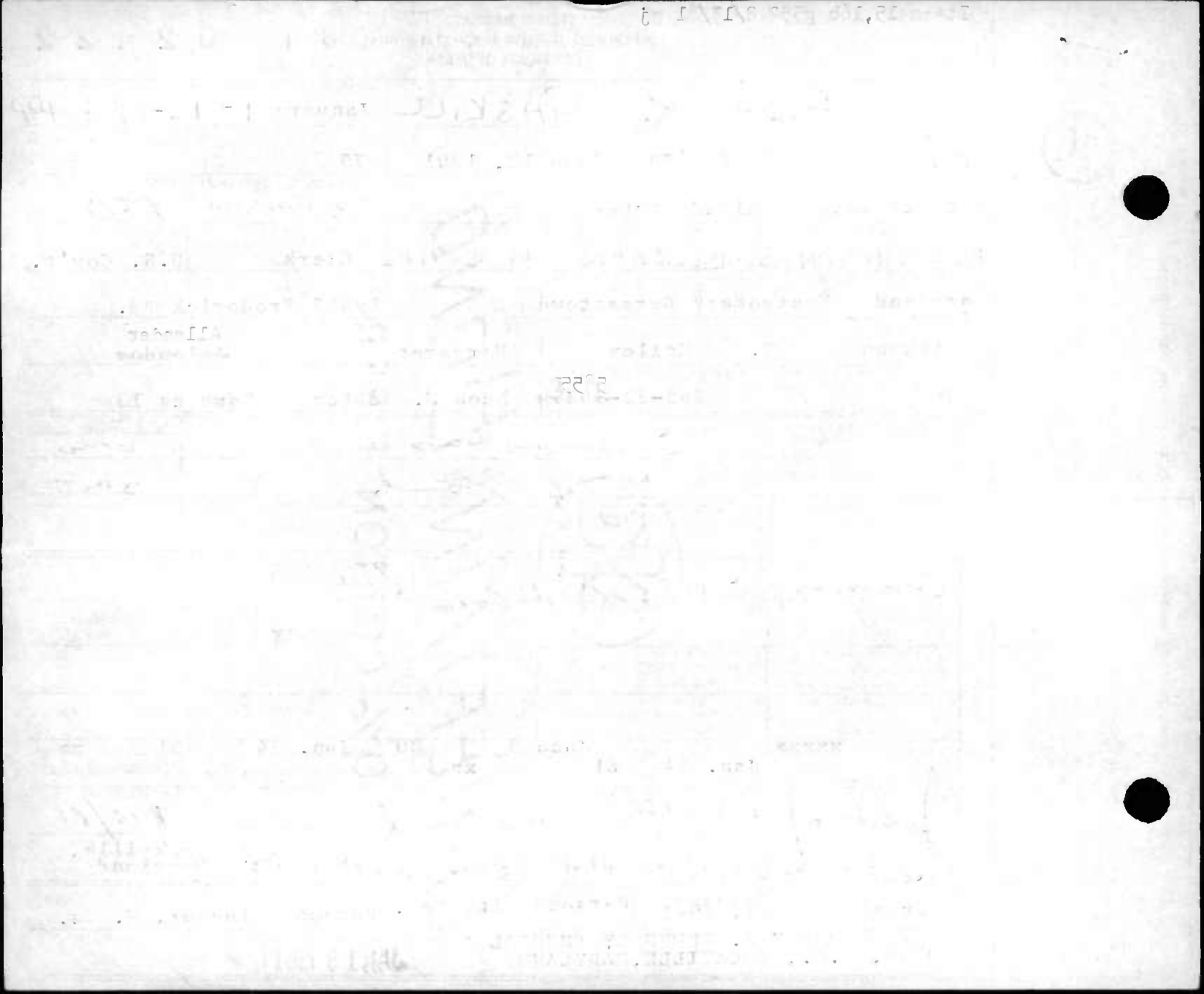
| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Stomach
DUE TO, OR AS A CONSEQUENCE OF (b) Ca of Stomach
DUE TO, OR AS A CONSEQUENCE OF (c) Ca of Stomach
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mo
6 mo + | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic CHF, ASHD, Pleuritis | | | | | |
| 19a. DATE OF OPERATION
1519 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CHF, ASHD, Pleuritis | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 3, 1980 to Jan. 14, 1981 , that (I) (we) last saw the deceased alive on Jan. 14, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John S. Saia | | DEGREE
MD | | 22c. DATE SIGNED
1/15/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John S. Saia | | 22e. ADDRESS
Westphal 809 Viers Mill Rd | | 22f. CITY OR TOWN
Rockville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
January 17, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Parsons City Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parsons Tucker, W. Va. | | 23e. DATE REC'D. BY REGISTRAR
JAN 19 1981 | | 23f. REGISTRAR'S SIGNATURE
[Signature] | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 2 3

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lilybelle Gattis | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 29, 1981 | | 2b. HOUR
8:45 A M | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
December 5, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | | |
| 12. CITY OR TOWN OF DEATH
Rockville | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rockville Nursing Home | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | 15. KIND OF BUSINESS OR INDUSTRY
Educator | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
Maryland | | | 16b. COUNTY
Montgomery | | 16c. CITY OR TOWN
Rockville | | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16e. STREET ADDRESS
5912 Muncaster Mill Road | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
Elias Price | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Francis Carlisle | | | | | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 20. SOCIAL SECURITY NO.
45-36-8707A | | 21. INFORMANT ADDRESS
Clara Shipe (Same as 13e) | | | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u>
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Known 5 years</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 23. DATE OF OPERATION | | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 25. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 28. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 30. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 31. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 32. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 33. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>76</u> , to <u>January 29</u> , 19 <u>81</u> , that (I) was lost saw the deceased alive on <u>January 25</u> , 19 <u>81</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | | | | |
| 34. SIGNATURE
<u>Aaron H. Traum</u> | | | 35. DEGREE
MD | | 36. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 37. DATE SIGNED
<u>January 30, 1981</u> | | | |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Aaron H. Traum MD</u> | | | 39. ADDRESS
<u>8415 Georgia Ave Silver Spring Md</u> | | | | | | | |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 41. DATE
Jan. 31, 1980 | | 42. NAME OF CEMETERY OR CREMATORY
Monocacy Cemetery | | 43. LOCATION
CITY OR TOWN COUNTY STATE
Beallsville MD | | | |
| 44. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | 45. ADDRESS
P.A., Rockville, Maryland | | 46. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 47. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

2
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 2 4

| | | | | | |
|---|---|--|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JENNIE | | JAN 27 81 | | 8:45 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| FEMALE | WHITE | MAY 25, 1895 | 85 | Montgomery MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| RUSSIA | U.S.A. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | HEBREW HOME OF GREATER WASHINGTON | GARMENT FINISHER | CLOTHING | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MARYLAND | MONTGOMERY | SILVER SPRING | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 11200 LOCKWOOD DRIVE | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | | |
| BENJAMIN | ZLOTA | NO | | | |
| 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS | | | | |
| SAMUEL J. BLACK, 10803 BLOSSOM LANE, SILVER SPRING, MARYLAND | 3 weeks | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27/81 to 1/27/81, that (I) (we) last saw the deceased alive on 1/27/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| D-D. PATEL | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 1/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| D-D. PATEL | | 6121 MONTROSE RD. Rockville, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| BURIAL | 1/29/1981 | JUDEAN MEMORIAL GARDENS | OLNEY, MONTGOMERY, MARYLAND | | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | FEB 2 1981 | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | |

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 1 0 2 4 2 5

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Robert | | MIDDLE
John | | LAST
GERHARDT | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 30 1981 | | 2b. HOUR
5:40A M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 28 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7300 Pomander Lane | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Gustav Gerhardt | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Augusta Johnson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-66 | | 17. INFORMANT
ADDRESS
Mrs. Marian M. W. Gerhardt See item 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Diffuse Bilateral Bronchopneumonia</u>
3320 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Parkinson's Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 10 1981, to Jan. 30 1981, that (I) (we) last saw the deceased alive on Jan. 30 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>GARY ZALOGA</u> | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 30 1981 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GARY ZALOGA | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, M.d. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Feb. 2, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Concordia Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Forest Park Cook Illinois | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Home | | | | ADDRESS
Bethesda, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |



CONFIDENTIAL

1962

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Item #15 Film G553 3/12/81 re

1- STATE REGISTRAR

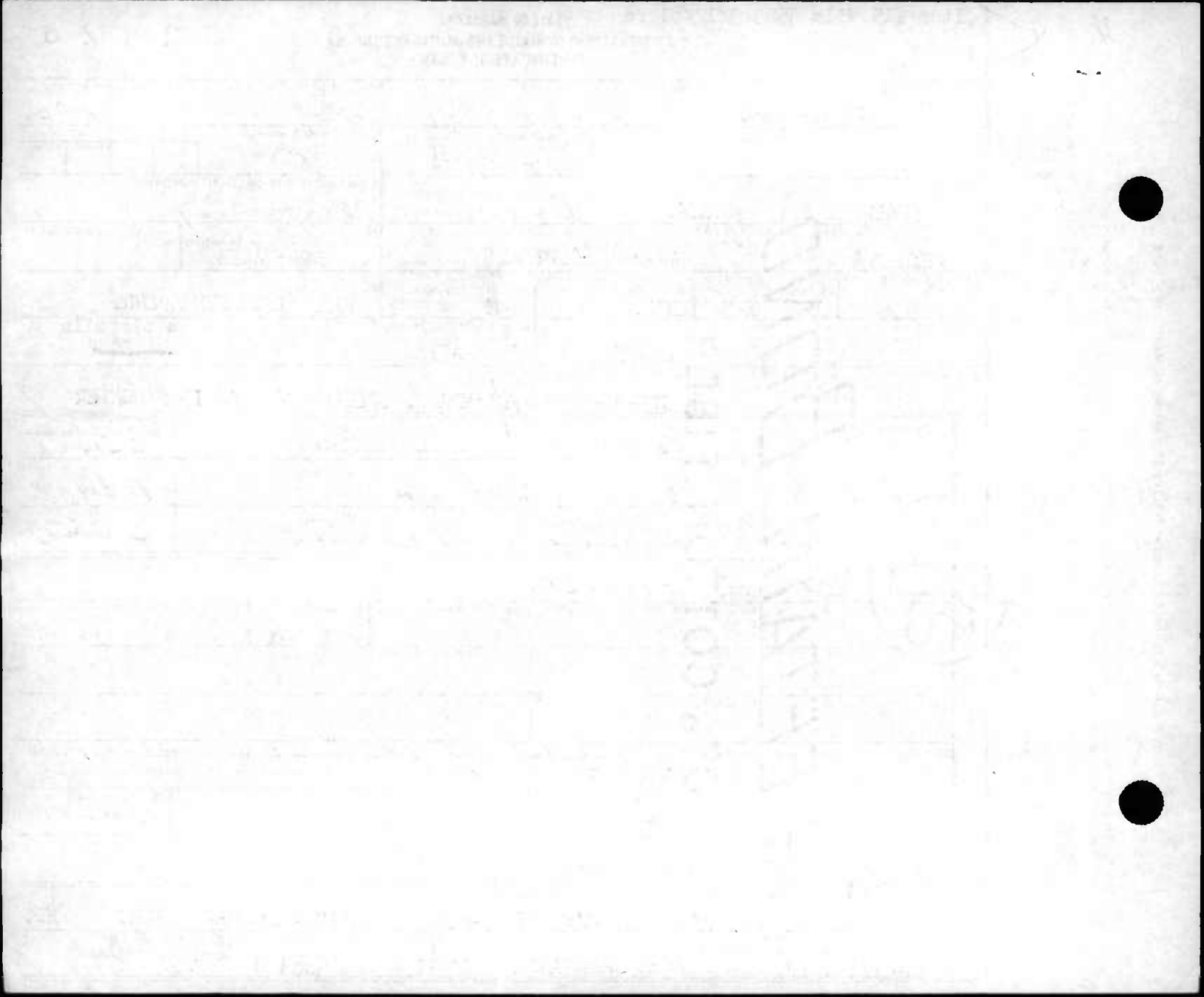
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 4 2 6

| | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FILOMENA GIAMPETRONI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-19-81 | | | 2b. HOUR
9:10 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 26, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 8. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PASQUALE CIATTI | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
MARIA Battistella GARTONE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
577-03-5069 | | | | 17. INFORMANT
ADDRESS
YOLANDA G. COLELLA SAME AS 13 DAUGHTER | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary + Pulmonary Failure
2502
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) HYPEROSMOLAR COMA
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia + Dehydration | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
10 days
2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 19 78 , to 19 Jan 81 , that (we) lost saw the deceased alive on 19 Jan 81 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eugene P. Libre MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
19 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. LIBRE MD | | | | | | 22e. ADDRESS
10410 CONN AVE KENSINGTON MD. 20745 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
20901 JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
History McBrady | |

BP



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 1 0 2 4 2 7

REG. NO.

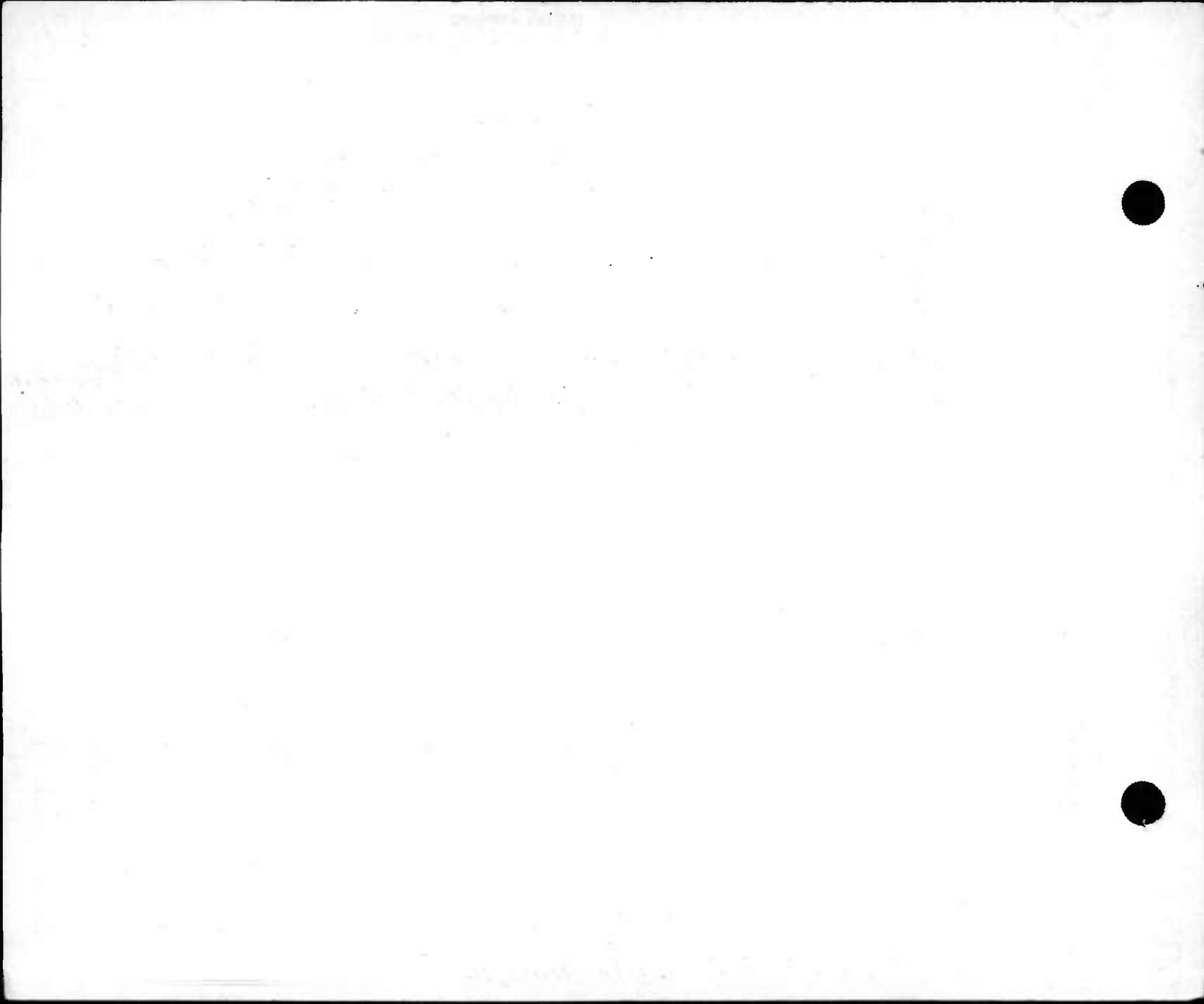
 1. FOR
 STATE
 REGISTRAR

| | | | | | | |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LARA A GIBSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11/8/81 | | 2b. HOUR
6:30 AM | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
7 07 95 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont Co MD | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT, IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF YEAR)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | 13c. CITY OR TOWN
Mont Co Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10705 Jamaica Dr | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN LINTECUM | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CELIA JENNINGS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
443-267186 | 17. INFORMANT
ADDRESS
HAROLD GIBSON, SILVER SPR. Md.
10705 JAMAICA DR. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Melanotic C (Two lymph nodes)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>a stroke of stomach</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>8-12 mo.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | |
| 19a. DATE OF OPERATION
1/8/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
L & S obstruct | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/7 to 1/8, 1981, that (I) (we) last saw the deceased alive on 11/7, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
M. EICHLEK | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11/8/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. EICHLEK | | 22e. ADDRESS
3915 FERRARA D. Wheat, Md 20906 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
1-20-1981 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND PG. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
WIN CHAMBERS CO. | | ADDRESS
8655 GEORGIA AVE
SILVER SPRING, MD | | DATE REC'D. BY REGISTRAR
JAN 26 1981 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MILTON G GIENAU | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN 24 1981 | | 2b. HOUR
100 A.M. | |
| 3 SEX
Male | 4 RACE
CAUCASIAN | 5 DATE OF BIRTH
MONTH DAY YEAR
MAR 4 1992 | | 6 AGE (IN YEARS LAST BIRTHDAY)
88 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEBRASKA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BARBER | | 12b. KIND OF BUSINESS OR INDUSTRY
HAIR CUTTING | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
KENSINGTON | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GUSTAVE - GIENAU | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
rn/k rn/k rn/k | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
508-10-5686 | | 17. INFORMANT
MELVIN GIENAU | | |
| | | ADDRESS
14821 Seneca Rd | | CITY OR TOWN
GERMANTOWN MD | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **SEPTICEMIA**

5770
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ACUTE PANCREATITIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 DAY

1-2 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I, this hospital) attended the deceased from July 18, 1980 to Jan 24, 1981 , that (I/we) lost
saw the deceased live on Jan 23, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (I/we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Martin C. Shargel M.D. | | | | DEGREE | | 22c. DATE SIGNED
1/24/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL | | | | 22e. ADDRESS
3720 FARRAGUT AVE
KENSINGTON, MD - 20795 | | | |

| | | | |
|---|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
JAN 26 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland P.G. MD |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers & Co Inc | | ADDRESS
8655 Georg. Ave
Sil Spg Md | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

APR 24 1981 CAL

MILTON G. CLEVER

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

MADE

Orig. certif. rec'd on old form. Used Dr's sig. from orig. See K.M. H. Folder

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 2 9 | | | |
|---|--|--|--|---|--|--|---|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Leona W. Gindele | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 21, 1981 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 17, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1009 Madison St. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Kensington 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 11009 Madison St. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur Caston Richards | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not Available | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT Richmond, Va. ADDRESS Rd. Dotti E. Grant, Daughter, 4531 W.W. Seminary | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) 4409
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) K91 Haemodiscs | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
yrs. |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December , 19 71 , to Jan. , 19 81 , that (I) (we) last saw the deceased alive on Jan. 18 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles Farwell | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles Farwell, M.D. | | | | 22e. ADDRESS
11406 Viers Mill Rd., Wheaton, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Va. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Takoma Funeral Home, 254 Carroll St., N.W.D.D. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert H. [Signature] | |



Handwritten signature or initials, possibly "K. J. [unclear]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DOCTOR JOHN ROGERS AND RELEASED PER DR. EVA MORELL, MD.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 3 0 | | | |
|--|--|---|--|--|--|--|--|
| 1 - FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
LILLIAN T GOLDBERG | | | | 2a DATE OF DEATH MONTH DAY YEAR
JAN. 7 1981 | | 2b HOUR
10:30 ^{AM} | |
| 3 SEX
FEMALE | | 4 RACE
CAUCASIAN | | 5 DATE OF BIRTH
MONTH DAY YEAR
2 16 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PHILA. PA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | |
| 10 CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RESIDENCE: 6813 TILDEN LA. | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b KIND OF BUSINESS OR INDUSTRY
ELECTRICAL | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MD 13b COUNTY MONT. 13c CITY OR TOWN ROCKVILLE | | | | 13d ESTATE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
6813 TILDEN LA ROCKVILLE MD | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
HENRY --- TAPLINGER | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK. --- GOLDSTEIN | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b SOCIAL SECURITY NO.
159-20-9911 | | 17 INFORMANT
ADDRESS
MRS. JANICE OLTMAN ROCKVILLE MD 20852 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Generalized arteriosclerosis</u>
8-10 years
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Old age</u> | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 months | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a DATE OF OPERATION
--- | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
--- P.M. --- | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
--- | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
--- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
--- | | | |
| 22a. I certify that I (we) attended the deceased from <u>October 1980</u> to <u>Dec. 5</u> , 19 <u>80</u> , that I (we) last saw the deceased alive on <u>Dec. 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>E. Morell</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
JAN. 7 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. EVA M. MORELL MD | | | | 22e. ADDRESS
7936 OLD GEORGETOWN RD. BETHESDA MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
JAN 11-81 | | 23c. NAME OF CEMETERY OR CREMATORY
MONTEFIORE CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FOX CHASE PENN. | |
| 24 FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

BP

DHMH-16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 3 1

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edgar Dean Golden | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 21, 1981 | | 2b. HOUR
1:40PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 25, 1934 | 6. AGE (IN YEARS LAST BIRTHDAY)
46
YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nebraska | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, Bethesda, Md (NIH) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Purchasing Mgr. | 12b. KIND OF BUSINESS OR INDUSTRY
Vickers Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Arkansas | | | 13b. CITY OR TOWN
Searcy | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
218 Indian Trail, 72143 |
| 14. FATHER'S NAME
Noel Golden | | | 15. MOTHER'S MAIDEN NAME
Julia Jean Ruhge | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE BRANCH AND DATES)
Yes Korea | | 16b. SOCIAL SECURITY NO.
506405056 | 17. INFORMANT
ADDRESS
Mrs. Patricia Golden (same as above) | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary emboli
4254
DUE TO, OR AS A CONSEQUENCE OF (b) Idiopathic cardiomyopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | |
|---|---|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from January 3, 1981, to January 21, 1981, that (I) we last saw the deceased alive on January 21, 1981, and that in (XX) our opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
P. Gascon MD | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PEORO GASCON, MD. | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md. 20205 | | |

| | | | |
|---|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
Jan. 26 | 23c. NAME OF CEMETERY OR CREMATORY
Rosewood Cemetery | 23d. LOCATION
Palmyra, Nebraska STATE |
| 24. FUNERAL DIRECTOR
NAME
Pearson's Funeral Home
Falls Church, Va. 22046 | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | 25b. REGISTRAR'S SIGNATURE
[Signature] |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

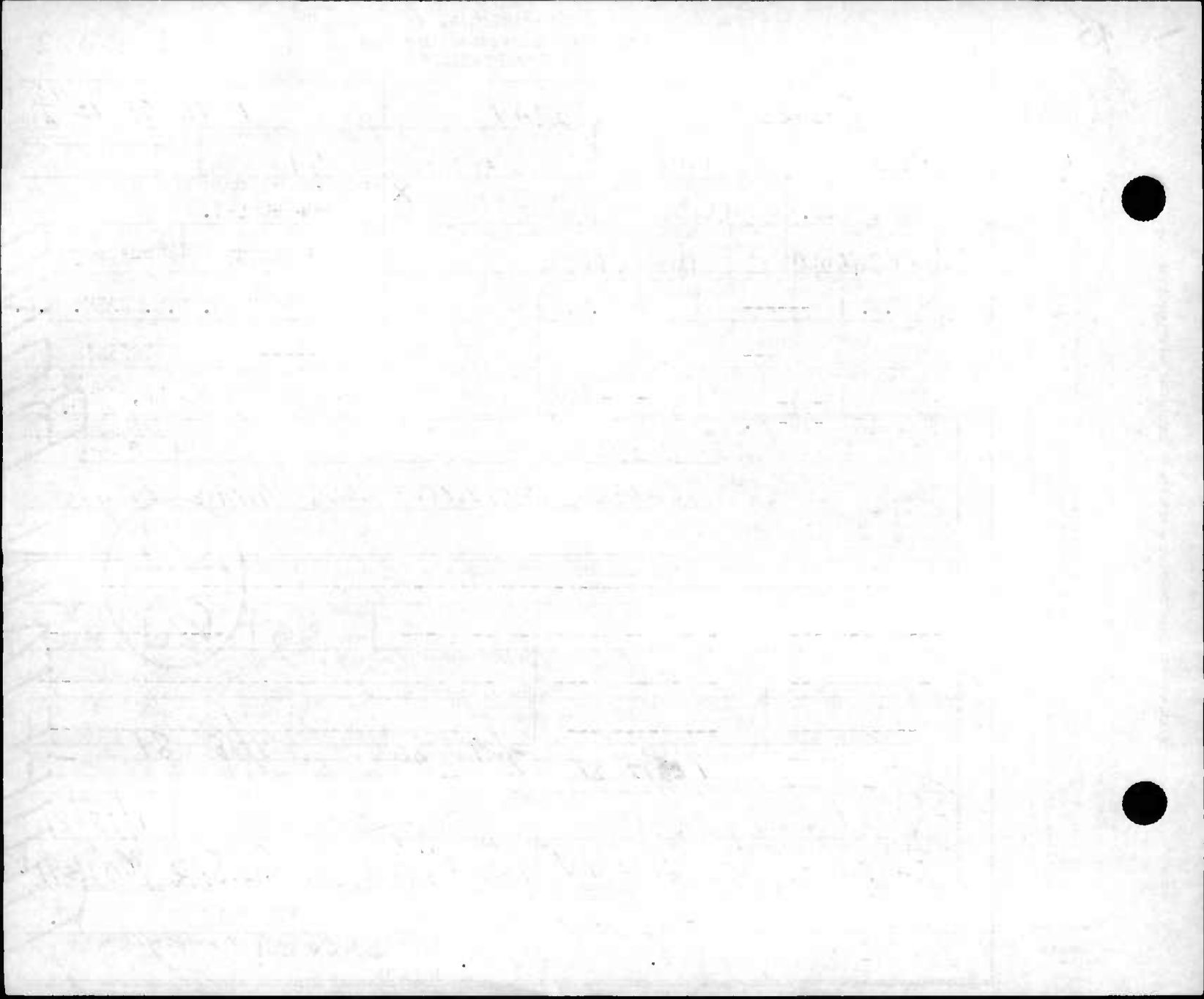
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 4 3 2

| | | | | | | | |
|--|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ISADORE GORAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 18 81 | | 2b. HOUR ¹⁸
12 4 M | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 31 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS
IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BOSTON, MASS. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY. MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PHARMACIST | | 12b. KIND OF BUSINESS OR INDUSTRY
PHARMACY | |
| 13a. STATE
WASH D.C. | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
WASH D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
3636 16th st. N.W. WASH. D.C. | | 14. FATHER'S NAME
FIRST MIDDLE LAST
HYMAN ----- GORON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
REBECCA ----- PETOFSKI | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES
(IF YES, GIVE WAR OR DATES) 8-29-42 to 9-16-44 | |
| 16b. SOCIAL SECURITY NO.
578-07-2255 | | 17. INFORMANT
HERBERT KUSHNER | | ADDRESS
6313 TILDEN LA. ROCKVILLE MD. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEIZURE
4960
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) 20 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
----- | | | | | | | |
| 19a. DATE OF OPERATION
----- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
----- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
----- P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
----- | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
----- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3/29 80 1/18 81 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18/81 to 1/18/81 , that (I) was last saw the deceased alive on 1/18/81 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I was did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ralph E. Beligmann | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/18/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RALPH E. BELIGMANN | | 22e. ADDRESS
8630 FENTON ST. SIL. SPR., MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1-21-81 | | 23c. NAME OF CEMETERY OR CREMATORY
SHOMRE HADATH CEM | | 23d. LOCATION
CITY OR TOWN COUNTY MD.
ROSEDALE | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEM CHAP. | | | | 25a. DATE
JAN 20 1981 | | | |

BP



Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

Page 4 may be

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 3 3

REG. NO.

| | | | | | | |
|--|--|--|---|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KATHYRM H BRAVES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-8-81 | | 2b. HOUR
9:58 AM | |
| 3. SEX
F | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 25 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD |
| 10. CITY OR TOWN OF DEATH
Rockville, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Teacher Schools | | 12b. KIND OF BUSINESS OR INDUSTRY
D.C. |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank A. Hughes | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Wallace | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | |
| 17a. SOCIAL SECURITY NO.
216-46-9333 | | 17. INFORMANT (daughter) 12701 Layhill Road,
Paula G. Snapp-Silver Spring, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u>
5715
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2/81 to 1/8/81, that (I) (we) lost
saw the deceased alive on 1/3/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/8/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN MD | | 22e. ADDRESS
2309 SHOREFIELD RD
WHEATON MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-10-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Pumphrey, Inc. | | ADDRESS
8434 Ga. Ave., S.S. Md. | | 25a. DISEASED BY
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |



Handwritten signature or initials.

THE NATIONAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 3 4 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Harry Greenberg | | | | 2a. DATE OF DEATH
MONTH 1 DAY 19 YEAR 81 HOUR 4 MIN 10 AM | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH Mar DAY 15 YEAR 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Grocer | | 12b. KIND OF BUSINESS OR INDUSTRY
Ret. Grocery | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Aaron MIDDLE Greenberg LAST Greenberg | | 15. MOTHER'S MAIDEN NAME
FIRST Simma MIDDLE unk. LAST unk. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT
ADDRESS
Sumner, Md., Leonard Greenberg, 4990 Sentinel Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4140
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) 10 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HR. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 1, 1980 to JAN. 19, 1981 , that (I) (we) lost
saw the deceased alive on JAN. 18, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Saul Zukerman MD | | | | DEGREE
MD | | 22c. DATE SIGNED
1-19-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Saul Zukerman | | | | 22e. ADDRESS
5410 CONNECTICUT AVE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Jan. 20, 81 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hyattsville P. G. Md. | |
| 24. FUNERAL DIRECTOR
NAME Danzansky-Goldberg, Inc. ADDRESS Rockville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

1-22-83

1-22-83

1-22-83

1-22-83

1-22-83

1-22-83

1-22-83

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

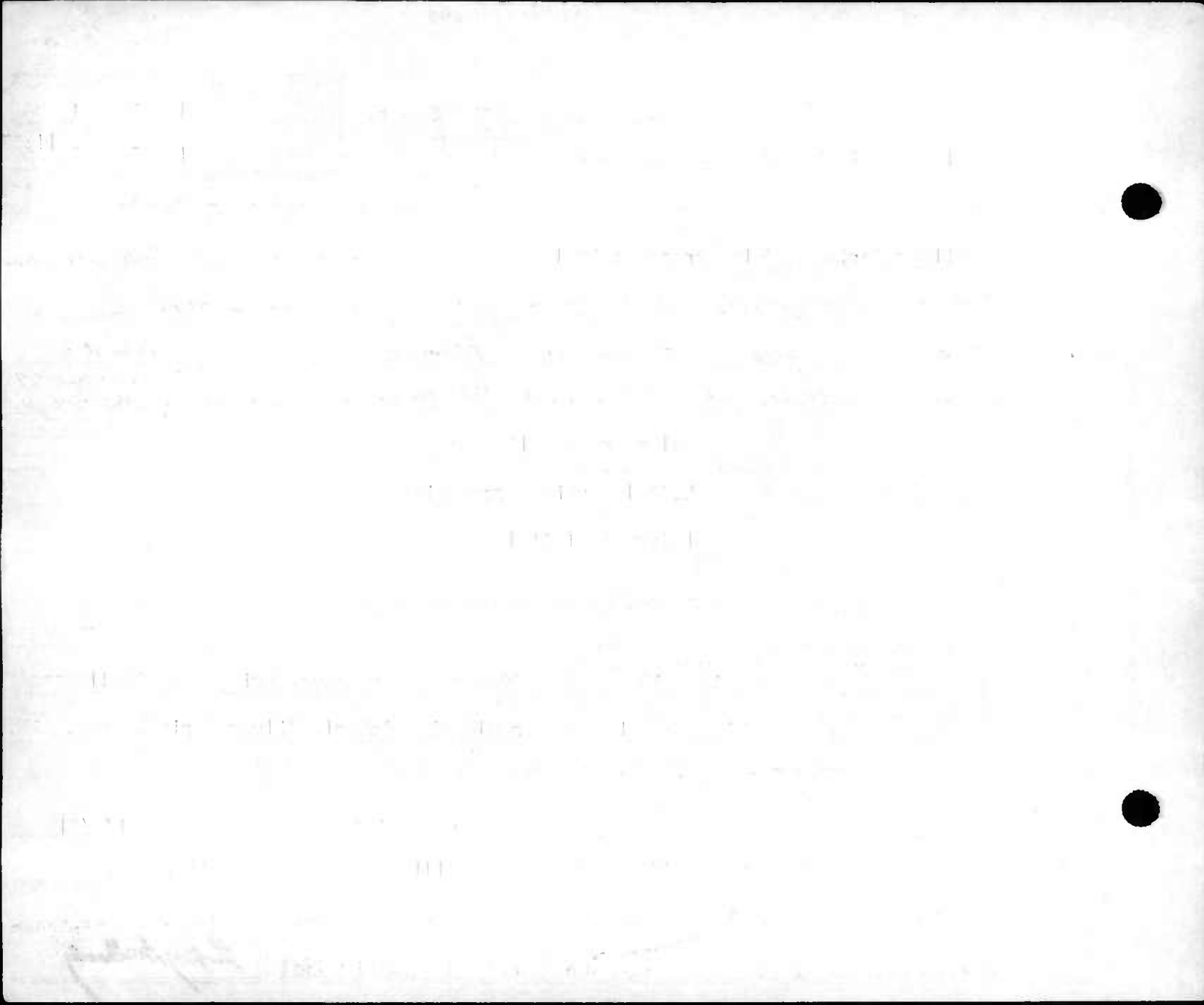
02435

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|------------------|---|----------------|------------------|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2b. DATE KNOWN OF DEATH ESTIMATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Ocie Lee Greene, JR. | | | MONTH DAY YEAR
1 7 19 81 | | | MONTH DAY YEAR
1 7 19 81 | | | 11:37 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | |
| Male | Black | 3 5 53 | 27 YRS. | MONTHS | DAYS | SEAFORD, DEL | | | U.S.A. | | |
| 8. MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | |
| NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Montgomery County, MD | | | Silver Spring | | | Holy Cross Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. STATE | | | 13b. COUNTY | | |
| Staff Specialist | | | Vistro Laboratories | | | MARYLAND | | | MONTGOMERY | | |
| 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | 14. FATHER'S NAME | | |
| SILVER SPRING | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 3402 NIMITZ ROAD | | | OCIE LEE GREENE SR. | | |
| 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| ROSALIE WINDER | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | | 221-36-6530 | | | MARSHA GREENE | | |
| ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| 8502-16 St. Apt. 107 | | | PART I DEATH WAS CAUSED BY: | | | 19c. AUTOPSY? | | | 20. DATE OF OPERATION | | |
| Silver Spring, Md 20910 | | | IMMEDIATE CAUSE (a) Pulmonary emboli | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. TIME OF INJURY | | |
| | | | (b) Left leg vein thrombosis | | | | | | 8:15 A.M. 12 8 19 80 | | |
| | | | (c) Injury to left leg | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| | | | | | | | | | Strenuous movements during basketball game | | |
| | | | | | | | | | 21d. INJURY OCCURRED | | |
| | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | |
| | | | | | | | | | high school gym | | |
| | | | | | | | | | 21f. LOCATION | | |
| | | | | | | | | | Argyle High School, Silver Spring, Mont., MD. | | |
| | | | | | | | | | 22a. I certify that I took charge of the remains described above, held an | | |
| | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | |
| | | | | | | | | | death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | |
| | | | | | | | | | 22b. DATE REC'D. BY REGISTRAR | | |
| | | | | | | | | | JAN 16 1981 | | |
| | | | | | | | | | 22c. REGISTRAR'S SIGNATURE | | |
| | | | | | | | | | Ricky McHenry | | |

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | |
|---|--|--|-------------------------------|--|--|------------------------------------|--|--|-------------------------------|--|--|----------------------------|--|--|-------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (CITY OR TOWN) | | | 23e. COUNTY | | | 23f. STATE | | |
| BURIAL | | | 1-13-81 | | | NEW ZION U.M. Cemetery | | | LAUREL | | | SUSSEX | | | DELAWARE | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | 25c. DATE REC'D. BY REGISTRAR | | | 25d. REGISTRAR'S SIGNATURE | | | 25e. DATE REC'D. BY REGISTRAR | | |
| NAME | | | ADDRESS | | | ADDRESS | | | ADDRESS | | | ADDRESS | | | ADDRESS | | |
| Jolley's Memorial Chapel | | | Rt. #2 Jersey Rd | | | Salisbury, Md 21801 | | | JAN 16 1981 | | | Ricky McHenry | | | JAN 16 1981 | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 2 4 3 6
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Anna Gross</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>1 25 81</i> | | 2b. HOUR
<i>4:55 AM</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>March 12, 1902</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>78</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Russia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Prod. Worker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Clothing</i> | |
| 13a. STATE
<i>Md</i> | | 13b. CITY OR TOWN
<i>Rockville</i> | | 13c. STREET ADDRESS
<i>6121 Montrose Road</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Nathan Packter</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Helen Cooperman</i> | | 16. SOCIAL SECURITY NO.
<i>067-03-0959</i> | | 17. INFORMANT
<i>Mrs. Edna Tepper; 701 Hyde Rd., SSpg</i> | |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 19. (IF YES, GIVE WAR OR DATES)
<i>-----</i> | | 20. ADDRESS
<i>Md.</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *cardiac asystole**4360*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *massive stroke*

DUE TO, OR AS A CONSEQUENCE OF

(c) *atherosclerosis*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*10 minutes**2 days**years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January 24, 19 81</i> , to <i>Jan 25, 19 81</i> , that (I) (we) last saw the deceased alive on <i>Jan 25, 19 81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Mark S. Rosen MD</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1/25/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MARK S. ROSEN, M.D.</i> | | | | 22e. ADDRESS
<i>1131 University Blve W., SSpg, Md.</i> | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1-27-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Union Fields Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Brooklyn, New York</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i> | | | | 25a. DATE REG'D. BY REGISTRAR
<i>JAN 28 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



INSD C-IX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

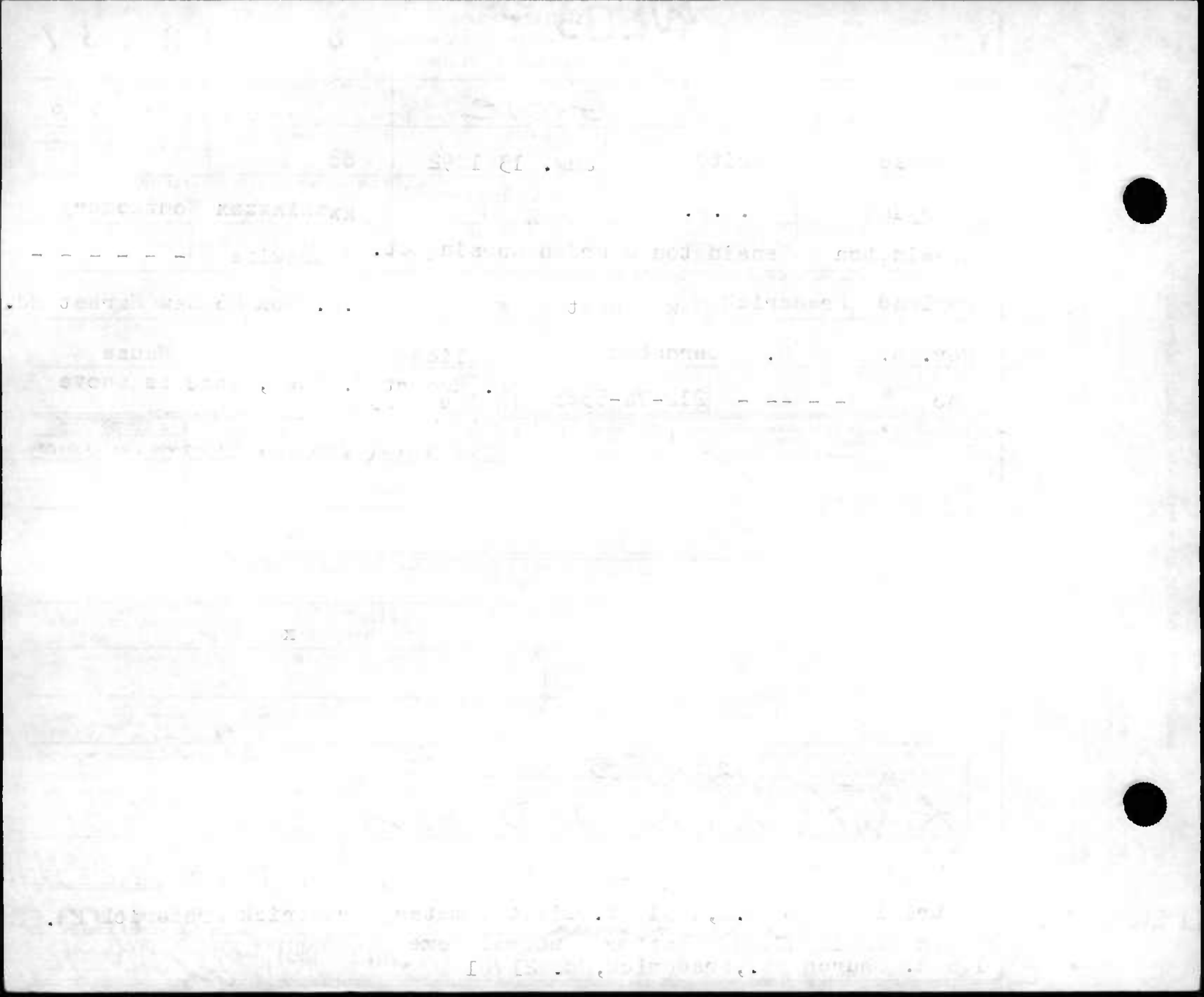
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 3 7
REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Margaret I. Grove</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1-3-1981</i> | | | | 2b. HOUR
<i>6²⁰ PM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Aug. 13 1892</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>88</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS
<i>YRS.</i> | | 7b. IF UNDER 24 HRS. HOURS MIN.
<i>YRS.</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Kensington Montgomery MD</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Kensington Garden Nursing C.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>- - - - -</i> | | | |
| 13a. STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Frederick</i> | | 13c. CITY OR TOWN
<i>New Market</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Rev. B. R. Carnahan</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Alice Hauso</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>no</i> | | | | 16b. SOCIAL SECURITY NO.
<i>212-74-5325</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Robert G. Tuck, same as above in item #13</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cerebral Vascular Disease</i>
<i>4370</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 years</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>2/9</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>1/1/ 1978 to 1/3/ 1981</i> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/1/ 1978</i> to <i>1/3/ 1981</i> , that the (we) last saw the deceased alive on <i>12/26/ 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert C. Macon</i> M.D. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
<i>1/3/81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Robert C. Macon</i> | | | | | | 22e. ADDRESS
<i>809 Viers Mill Rd. Rockville, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | | 23b. DATE
<i>Jan 6, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Olivet Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Frederick Frederick Md.</i> | | | |
| 24. FUNERAL HOME
<i>Frederick Kennedy Ballard Funeral Home</i>
106 E. Church St., Frederick, Md. 21701 | | | | | | DATE REC'D. BY REGISTRAR
<i>JAN 7 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8102438 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST Louis MIDDLE Jean LAST GROVEN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 81 2b. HOUR 9 P.M. | | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Belgian | | 7b. CITIZEN OF WHAT COUNTRY? Belgium | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Diplomate | | 12b. KIND OF BUSINESS OR INDUSTRY Government | |
| 13a. STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Chevy Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Henri MIDDLE Jean LAST Groven | | 15. MOTHER'S MAIDEN NAME FIRST Anthony MIDDLE Notelaert LAST Notelaert | | 13e. STREET ADDRESS 6401 Shadow Rd. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Simone Groven Same as item # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
4360
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16 , 19 81 , to 1/18 , 19 81 , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joel Schallman DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schallman | | | | 22e. ADDRESS 9410 Old Georgetown Rd Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/20/81 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. | | | | DATE RECEIVED BY REGISTRAR JAN 22 1981 REGISTRAR'S SIGNATURE | | | |
| 5130 Wisc. Ave. N.W. Wash., D.C. | | | | | | | |

NOVOR

Figure 1

1100

6195-5-60

ગાંધીજીનાં

Life

•

0201020

7. *သုတေသန*

20705

Index

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

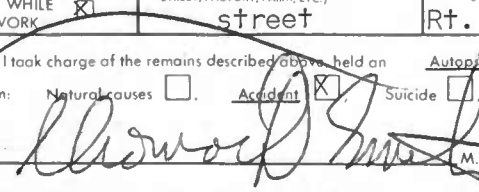
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH


REG. NO. 02439

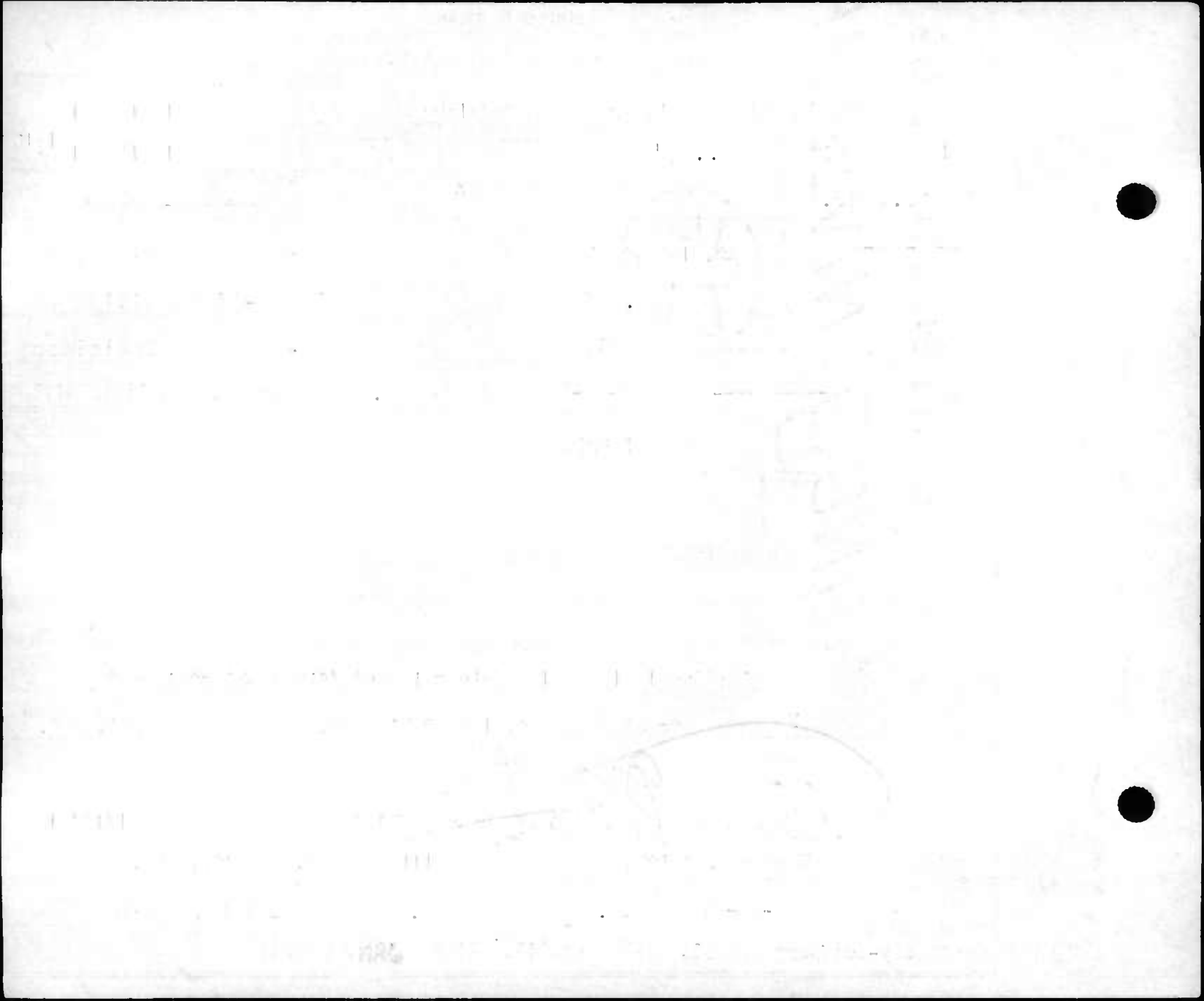
1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|---|---|------------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Howard Richard Gudelsky | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
1 15 81 | | | 2b. HOUR
M
11:10 A M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sep. 4, 1945 | 6. AGE (IN YEARS)
LAST BIRTHDAY
35 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1 15 81 | | |
| 7a. BIRTHPLACE (STATE OR COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
----- | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rt. 108 at Zion Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Gift Shop |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Mt. Airy | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isadore ----- Gudelsky | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha ----- Schleider | | 13e. STREET ADDRESS
2500 Mu-linx Mill Road | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT ADDRESS
Shelley A. Gudelsky; 2500 Mullinix Mill Rd | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8150 IMMEDIATE CAUSE (a) Neck injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10. | | |

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:45xx 1 15 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver in auto/fixed object impact | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 108 at Zion Rd. Mont., MD. | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Deputy Chief | | DATE SIGNED
1/16/81 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | ADDRESS
111 Penn St. Balto., MD. | | | |

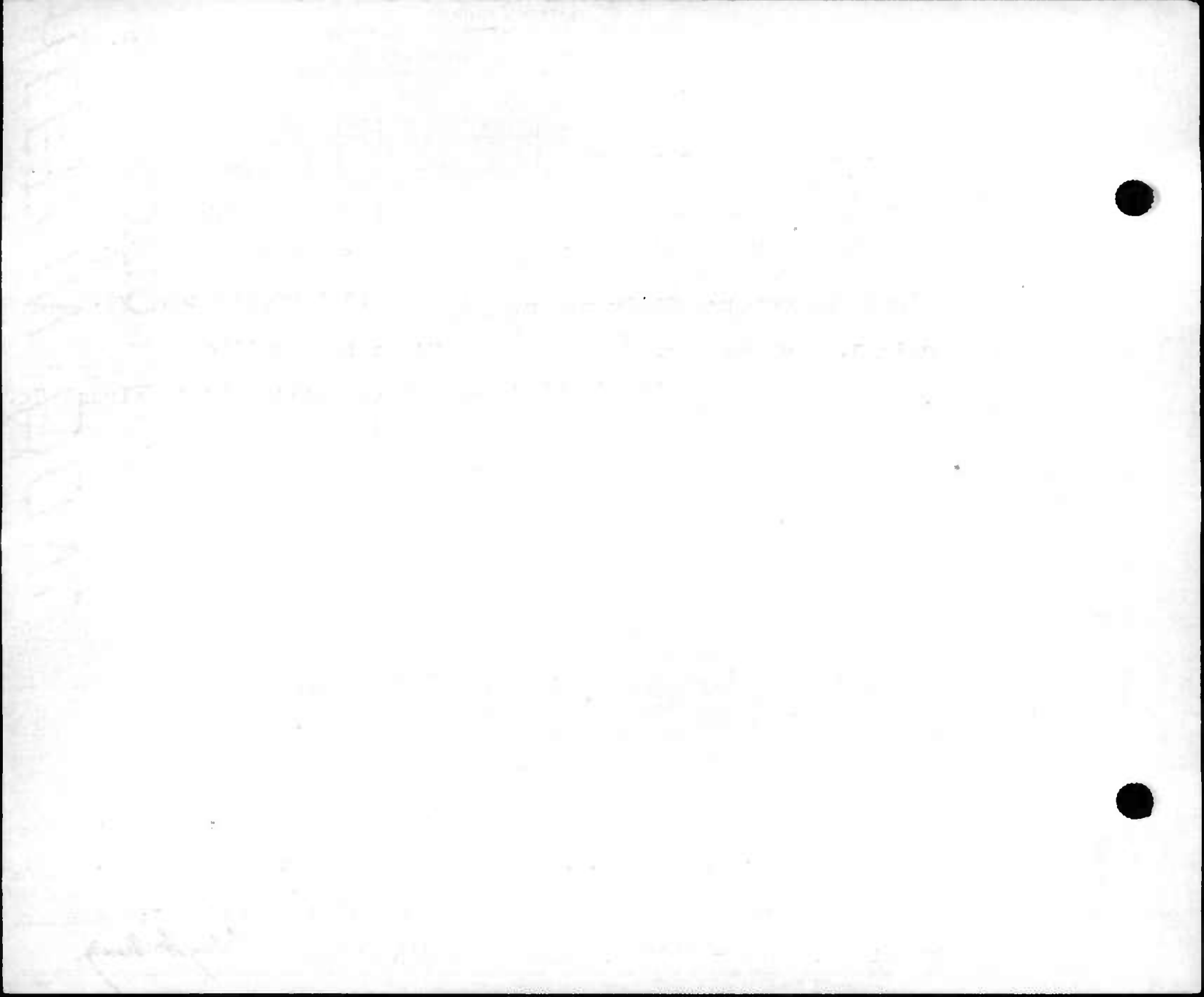
| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-18-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Geo. Washington Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hystatsville, Maryland | |
| 24. FUNERAL DIRECTOR
DanZansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE
 | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 0-2440 | |
|--|--|---------------------------|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
KAREN LOUISE HACKNEY | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
1 5 19 81 | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
9 23-58 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
22 YRS | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
1 5 19 81 | | 7d. HOUR
3:28 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana Indianapolis | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1300 Caddington Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
College | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spr. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1305 Caddington Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Louis J. Hackney Jr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Clara L. Hamilton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No. | | | | 16b. SOCIAL SECURITY NO.
305-68-2513 | | 17. INFORMANT ADDRESS
Mrs. Linda Collins-2401 Calvert St. N.W. Wash.D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Gunshot Wounds of Head
9654
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
2:00 PM 1 5 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION CITY OR TOWN STATE
1300 Caddington Ave. Silver Spring/ Montgomery MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan MD | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
1/5/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | | ADDRESS
111 Penn Street, Baltimore, MD. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/10/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
New Crown Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Indianapolis, Indiana | | | |
| 24. FUNERAL DIRECTOR NAME
Herbert E. Nutter | | | | ADDRESS
3035 W. North Ave. | | | | 25a. DATE REC'D BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
L. J. Nutter | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 8102441 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | |
| FIRST MIDDLE LAST
<i>Carl A. HAGEN</i> | | MONTH DAY YEAR
<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
<i>Jan 1981</i> | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) |
| <i>M</i> | <i>W</i> | MONTH DAY YEAR
<i>July 8 1908</i> | LAST BIRTHDAY
<i>72 YRS.</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| <i>WISCONSIN</i> | <i>U.S.A.</i> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <i>Montgomery MD.</i> |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| <i>S. J. Spg</i> | <i>Holy Cross Hosp.</i> | <i>ECONOMICS</i> | <i>LIB. OF CONGRESS</i> |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN |
| <i>MD.</i> | <i>Mont</i> | <i>S. J. Spg</i> | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FIRST MIDDLE LAST
<i>HERMAN HAGEN</i> | FIRST MIDDLE LAST
<i>HEDVIG GABEILEIN</i> | 13e. STREET ADDRESS
<i>7222mtmor Dr.</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| <i>YES</i> | <i>WW II</i> | <i>JULIA M. HAGEN</i> | <i>SAME AS 13 WIFE</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a). <i>Acute Myocardial Dis</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b). <i>Chronic Myocardial Dis</i> | | | <i>Yrs</i> |
| DUE TO, OR AS A CONSEQUENCE OF (c). | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<i>None</i> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| <i>None</i> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>John S. Rogers</i> | | TITLE (SPECIFY) <i>Doc</i> MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i> | | DATE <i>Jan 2, 1981</i> | |
| ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| <i>BURIAL</i> | <i>1/5/81</i> | <i>FORT LINCOLN</i> | <i>BRENTWOOD PRIGEO MD.</i> |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> | | 23e. DATE REC'D. BY REGISTRAR <i>JAN 5 1981</i> | |
| <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | 23f. REGISTER'S SIGNATURE <i>Anthony Kelm</i> | |

1400

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 1 0 2 4 4 2 | | | | | |
|---|--|--|--|--|---|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | | |
| FIRST MIDDLE LAST
Earl Joseph Hand | | | | | MONTH DAY YEAR HOUR
January 23 1981 11:35 A | | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
MARCH 6, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | | | |
| 12b KIND OF BUSINESS OR INDUSTRY
U.S. POSTAL SERVICE | | | | | | | | | | |
| 13a STATE
MARYLAND | | | | | 13b COUNTY
MONTGOMERY | | 13c CITY OR TOWN
SILVER SPRING | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET ADDRESS
3425 S. LEISURE WORLD BLVD. | | | | | | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
FRANCIS HAND | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA STEINBACH | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17 INFORMANT
MINNIE M. HAND | | ADDRESS
SAME AS 13 | | WIFE | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart M.I.</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ASCD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>74</u> to <u>1/23/81</u> , that (I) (we) lost saw the deceased alive on <u>1/23/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | | | DEGREE | | 22c. DATE SIGNED
1/23/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALLAN B. COHAN, M.D. | | | | | | 22e. ADDRESS
13975 Corn. Ave., S.S., Md. 20906 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
SILVER SPRING COUNTY MONT STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Harold H. Harding | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 4, 1981 | | 2b. HOUR
9:05pm | |
| 3. SEX
Male. | 4. RACE
White. | 5. DATE OF BIRTH
April 28, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Montg. Co, Md. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Auto Agency Dealer Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland. | 13b. COUNTY
Prince George | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
966 Nichols Dr. Laurel. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry G. Harding. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha D. Leizear. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | 17. INFORMANT
ADDRESS
Marian E. Harding. (Wife) 13 e. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cedrocarinoma of colon
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1.5 yrs. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Metastasis to bone, lungs, & liver; hepatic failure | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 79 , to 4 Jan , 19 81 , that (I) was last saw the deceased alive on 4 Jan , 19 81 , and that in (my) hour opinion death occurred on the date and hour and from the causes stated above; (I) will (did) not view the body after death. | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | 22c. ADDRESS
1811 Pr. Philip Dr
Olney, Md 20832 | | 22d. DATE SIGNED
5 Jan 81 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial. | | 23b. DATE
Jan. 7, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Union Cemetery, Burtonsville, Montg. Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
Arthur Watters | | 24b. ADDRESS
154 Carroll St N.W.
Washington D.C. 20012 | | 25a. DATE RECEIVED BY REGISTRAR
JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[The page contains extremely faint, illegible text and markings, possibly bleed-through from another document. Two punch holes are visible on the right side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 81 02444 | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Hettie SANXEY Harrison | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 12, 81 | | | | 2b. HOUR
11:30 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
NOV 11, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
GARRETT PARK | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ARNOLD J. STEWART | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ETTA M. HICKS | | | | 16. STREET ADDRESS
10712 KESWICK STREET | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
219-48-2418 | | 17. INFORMANT
BETTY H. CHANDLER | | 17. ADDRESS
DAUGHTER 419 N. E. STREET
BETHEL OHIO 45106 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) PANCREATITIS
5770
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
DIABETES, RENAL FAILURE, HEART DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/5 19 81, to 1/12 19 81, that (I) (we) lost saw the deceased alive on 1/12 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Daniel Rosenblum | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/12/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL ROSENBLUM MD | | | | 22e. ADDRESS
10400 CONNECTICUT AV
KENSINGTON MD 2095 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
1/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT MD. | | | |
| 24. FUNERAL DIRECTOR'S NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 2 4 4 5
CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JEANETTE I HART | | 1/9/81 | | 555 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | CAUCASIAN | AUG. 28-1934 | | 46 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| FRANCE | USA | | | MONTGOMERY CO. MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| SILVER SPRING | HOLY CROSS HOSPITAL | HOUSEWIFE | | OWN HOME | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | MONT. | | WHEATON | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| NOT KNOWN | | NOT KNOWN | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 579-504776A | | RONALD H. WOOD | | SAME AS ITEMS # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1749 Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) Cancer Left breast
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs
5 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25, 1978, to 1/79, 1981, that (I) (we) last saw the deceased alive on 1/79, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Hubert J. Alpert MD | | 22c. DATE SIGNED
1/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUBERT J. ALPERT | | 22e. ADDRESS
8630 FENTON ST
SILVER SPRING, MD. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| CREMATION | | 1/16/81 | | CEDAR HILL CREM | |
| 23d. LOCATION
(CITY OR TOWN) (COUNTY) (STATE) | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| SUITLAND- PG. MD. | | JAN 20 1981 | | [Signature] | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| W W CHAMBERS CO. SILVER SPRING MARYLAND | | JAN 20 1981 | | [Signature] | |

Prescribed by regulation at 10/1/77

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02446

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUTH BLACK HART | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 17 81 | | 2b. HOUR
MIN.
2:00 P. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 15, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Wheaton Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Librarian | 12b. KIND OF BUSINESS OR INDUSTRY
Library | |
| 13a. STATE
New York | | | 13b. COUNTY
Nassau Co. | 13c. CITY OR TOWN
Great Neck | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James - Black | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise - (Unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
ADDRESS
John G. Hart 1446 Q St. N.W. Washington, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1749 Metastatic Carcinoma of the Breast
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
2 9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 80 to 1/17 81 , that (I) (we) lost
saw the deceased alive on 1/16 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Morton Kavalier | | | | 22c. DATE SIGNED
1/17/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morton Kavalier | | | | 22e. ADDRESS
1145 19th St. N.W. WASH D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
JAN 23 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | |
| 24. FUNERAL DIRECTOR
NAME
Chambers Funeral Home | | ADDRESS
Silver Spring, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JAN 27 1981 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

BP

[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02447

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Beulah V Hawkins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 04 81 | | | 2b. HOUR
8:00 PM | | | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 26, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4001 Hampden St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES SHORTER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTIE GROSS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-20-9870 | | 17. INFORMANT
ADDRESS
Sylvia Simpson 3918 Merford St.
Kensington, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Atrial Fibrillation | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Stroke Congestive Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1981, to Jan. 4, 1981, that (I) (we) last saw the deceased alive on Jan. 4, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Boo K. Kim | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Boo K. Kim | | | | 22e. ADDRESS
16220 Frederic Rd, Maith, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1-9-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. WASH. ST.
Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

35
60
1
2
9
1
3502



4.2.1

4/25/2014

1001 Hamburg St.

OK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 4 4 8 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME | | | | | | | | | | 20. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | |
| HELEN M. HAWORTH | | | | | | | | | | 1-25-81 | |
| 3. SEX | | | | | | | | | | 2b. HOUR | |
| FEMALE | | | | | | | | | | 8:30 PM | |
| 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | |
| WHITE | | | | | | | | | | MONTH DAY YEAR | |
| 10-1-05 | | | | | | | | | | 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Penna. | | | | | | | | | | 75 | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| U.S.A. | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MONTGOMERY COUNTY MD. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| SILVER SPRING HOLY CROSS HOSPITAL | | | | | | | | | | Ret.-Telegrapher Western Union | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 13a. STREET ADDRESS | |
| 13a. STATE | | | | | | | | | | 3801 Connecticut Avenue, N.W. | |
| 13b. CITY OR TOWN | | | | | | | | | | 13c. INSIDE CITY LIMITS? | |
| Washington, DC | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | |
| Edward -- Kelly | | | | | | | | | | Frances -- Davidson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | |
| No | | | | | | | | | | 105-10-3615 | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | |
| June V. Anastasi | | | | | | | | | | 4316 Federal St., Rockville Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | 4415 | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | FATAL Failure | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | SHOCK | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Ruptured Aneurysm of Aorta | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 1-14-81 | | | | | | | | | | Ruptured Aneurysm of Aorta | |
| 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY | |
| | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | |
| 21c. INJURY OCCURRED | | | | | | | | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. LOCATION | |
| | | | | | | | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the undersigned) attended the deceased from 1-14-81, 1981, to 1-25-81, 1981, that (I) (we) lost | | | | | | | | | | 22c. DATE SIGNED | |
| saw the deceased alive on 1-25-81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | |
| L. Alberto Nunez MD | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| | | | | | | | | | | 8218 Wisconsin Ave. Bethesda, Md 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | |
| Burial/Transit | | | | | | | | | | 1/28/81 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | |
| Elm Cemetery | | | | | | | | | | Buffalo, New York | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | |
| Joseph Gawler's Sons, Inc. | | | | | | | | | | JAN 30 1981 | |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | | | | | [Signature] | |

BP

of Telephone Eastern Union

100 Connecticut Avenue, N. W.

Washington, D. C.

Division

Station

Room

Mr. J. V. Anderson, Jr., Director

100-10-100

10

Smith, New York

Director

Mr. Anderson

100-10-100

100-10-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02449

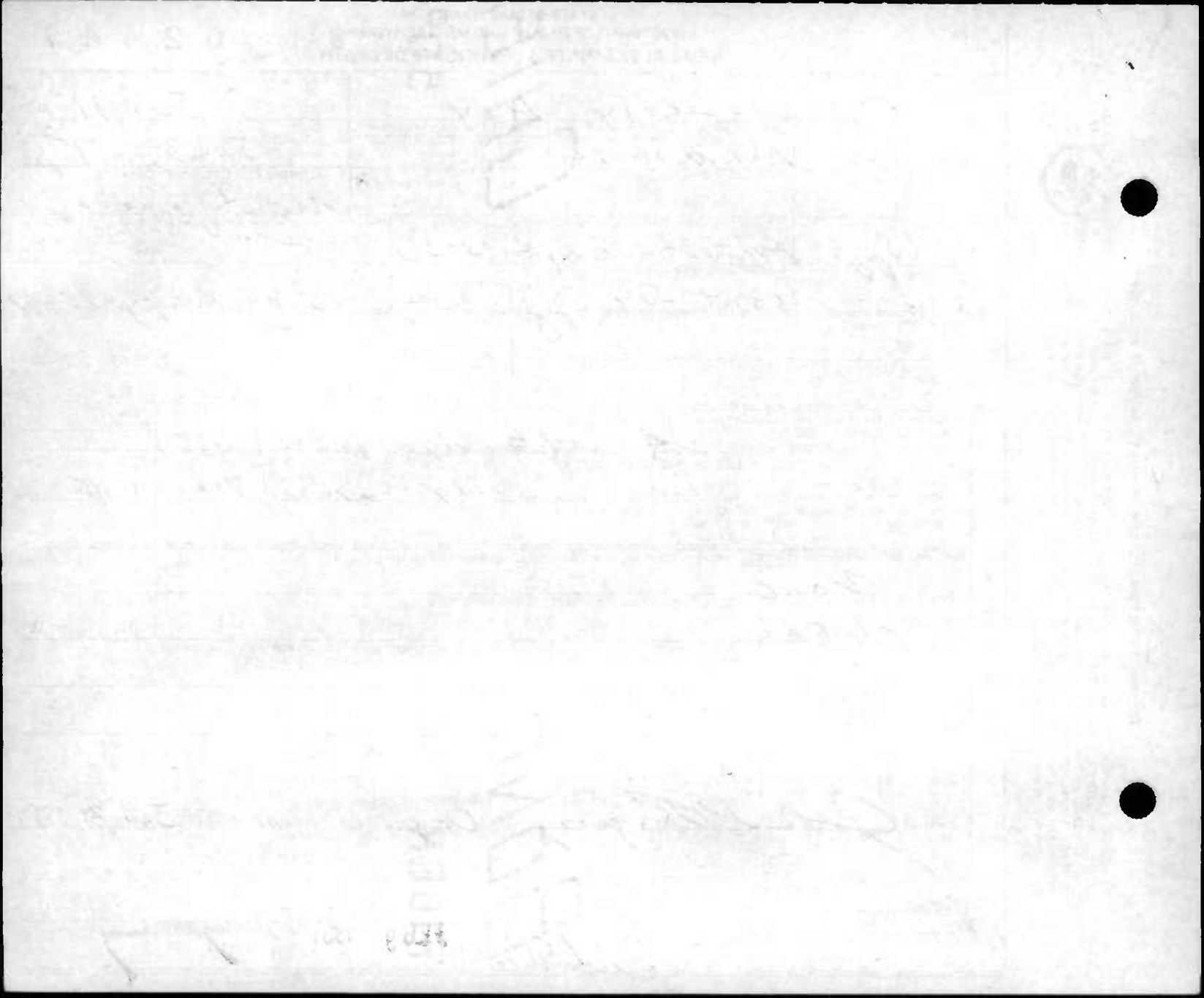
1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------|--|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN
OF DEATH | | | 2b. HOUR | | |
| Oscar Leroy | | | JAN 31 1981 | | | 11:50 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS
LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE
PRONOUNCED
DEAD | | 2d. HOUR |
| M | W | Nov. 8. 10 70 YRS. | 70 | | | JAN 31 1981 | | 11:50 AM |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Ohio | | USA | | | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. INDUSTRY
OR INDUSTRY |
| St. Louis | | 2715 18th Ave. Apt. 1505D | | | | Retired | | Civilian
Navy Dept. |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| Md | | | Mont | St. Louis | YES <input checked="" type="checkbox"/> XXXX | 2715 18th Ave. Apt. 1505D | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | | |
| Roland | | | Amela | | 324-05-2248 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (sister) | | | |
| no | | | 324-05-2248 | | Mildred E. Bowman-Pitts., Pa. 15235 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> | | | | | | | | 4291 |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) <u>Chronic Myocardial Dis.</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | 4291 |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| None | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| None | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL
SIGNATURE | | | TITLE (SPECIFY) | | | DATE | | |
| John S. Rogers | | | M.D. Dep. | | | JAN 31, 1981 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS | | | | | |
| John S. Rogers, DME | | | Silver Spring, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| CREMATION | | | Feb. 4, 1981 | | Metropolitan | | Alexandria Virginia | |
| 24. FUNERAL HOME OR
ADDRESS | | | 25. DATE REC'D. BY REGISTRAR | | 26. SIGNATURE | | | |
| Warner E. Pumphrey, Inc
8434 Ga. Ave., S.S. Md | | | FEB 9 1981 | | [Signature] | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS.
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 DHMH-17
 (V.R. 15 ME (5))
 15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 4 5 0 | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| FOR
STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Leland Stanford Hedgecock | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 14, 1981 | | | | 2b. HOUR
7:00 PM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 21 1902 | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bel Pre Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lawyer | | 12b. KIND OF BUSINESS OR INDUSTRY
Bell Tele.Co. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14207 Grand Pre Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
G. W. Hedgecock | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rodella Mount | | | | ADDRESS Silver Spring, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-10-0581 | | 17. INFORMANT
ADDRESS Margaret H. Smith 3606 Pimlico Place, | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure
4039
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Renal arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk.
4 YRS. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pneumonia, Generalized Arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26 , 19 80 , to 1/14 , 19 81 , that (I) (we) lost saw the deceased alive on 1/13 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 27a. SIGNATURE
Raymond Benack | | | | DEGREE M
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Jan. 14, 1981 | | | |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT)
Raymond Benack, M.D. | | | | 22e. ADDRESS
4115 Colie Dr. Wheaton, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
January 16 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Stonewall Memory Gardens Manassas | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Manassas Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey
ADDRESS Funeral Homes P/A 300 W. Montgomery Ave., Rockville, Md. 20850 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE
Henry McNeely | | | |

3204

1944
January 14, 1944
Madison, Tennessee
Dear Sir:

July 21, 1944
Silver Spring, Maryland
U.S.A.
Dear Sir:

Enclosed for you are two copies of a report on the results of the investigation conducted by the U.S. Army Medical Department at Silver Spring, Maryland, on July 10, 1944.

The report is being furnished to you for your information and for the information of the U.S. Army Medical Department at Silver Spring, Maryland.

Very truly yours,
Major General J. H. Dyer, U.S.A.
Director, U.S. Army Medical Department
Silver Spring, Maryland

#8, Film G552 2/18/81 kam

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 5 1

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
RICHARD GUSTAV HEINTZE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/20/81 | | | 2b. HOUR
11:40 P.M. | | |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1-1-39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D. C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wash. Adventist Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Musician | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | 13b. COUNTY
PG | 13c. CITY OR TOWN
Suitland | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3313 Swann Road | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gustav Heintze | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Wilson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
VietNam 093-32-1127 | | 17. INFORMANT
ADDRESS
Mildred Hubbard, Friend, Same as Above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
3352
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Angiopathic Lateral Sclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Weeks
3 years | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Malnutrition | | | | | | | | |
| 19a. DATE OF OPERATION
1/11/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastrostomy Tube | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4 PM 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (we) (we) (we) attended the deceased from 1/8/81 to 1/20 19 81 , that (I) (we) (we) (we) saw the deceased alive on 1/20 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (we) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Norton Elson MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NORTON ELSON | | 22e. ADDRESS
6525 Belcrest Rd Hyattsville MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-23-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Vet. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham, P.G., Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Robt E Wilhelm | | ADDRESS
4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02452

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Rudolph Paul HERTZOG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-20-81 | | 2b. HOUR
8:50AM | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 22 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BETHESDA RETIREMENT HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LAWYER | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
CHEVY CHASE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
6313 BROAD BRANCH ROAD | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Phillip HERTZOG | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY VOHNER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | |
| 16b. SOCIAL SECURITY NO.
216 44 4228 | | 17. INFORMANT
DOROTHY L. HERTZOG | | ADDRESS
SAME # 13 | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4340 cerebrovascular thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
quadraplegia | | | | | | | |
| 19a. DATE OF OPERATION
1-19-81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
quadraplegia | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICALEXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19-81 to 1-20-81 , that (I) (we) lost saw the deceased alive on 1-19-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald L. Bucy MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-20-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald L. Bucy | | 22e. ADDRESS
809 Veirs Mill Rd Rockville | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
JAN 23 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Md. | |
| 24. FUNERAL DIRECTOR
NAME
DEVOL FUNERAL HOME | | ADDRESS
WASH. DC | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
L. H. McCready | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at 1-800-368-5858.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopoppers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 7a, 7b, 8 g553 3/10/81 g3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-------------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Robert E. Hess | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Jan 20 19 81 | | | 2b. HOUR
M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1 12 04 | 6. AGE (IN YEARS)
LAST BIRTHDAY
76 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
1 22 19 81 | 2d. HOUR
405 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Dc | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
18211 Lost Knife Circle | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS
18211 Lost Knife Circle | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert E. Hess | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Esther Price | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes. WWII | | | | 16b. SOCIAL SECURITY NO.
224-52-1219 | | 17. INFORMANT
ADDRESS Glenn Dale, Md.
Shirley E. Moreland 12004 Augusta Dr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4960 IMMEDIATE CAUSE (a) PULMONARY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) SEVERAL YRS | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FOUND IN CHAIR AT HOME | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
118211 Lost Knife Circle Gaithersburg Mont Md | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
118211 Lost Knife Circle Gaithersburg Mont Md | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Francis C. Mayle | | M.D. | | MEDICAL EXAMINER | | DATE SIGNED Jan. 23, 81 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C. Mayle, M.D. | | ADDRESS
8200 Wisconsin Ave., Bethesda, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc.
5130 Wisc. Ave. N.W. Wash., D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert E. Hess | | |

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

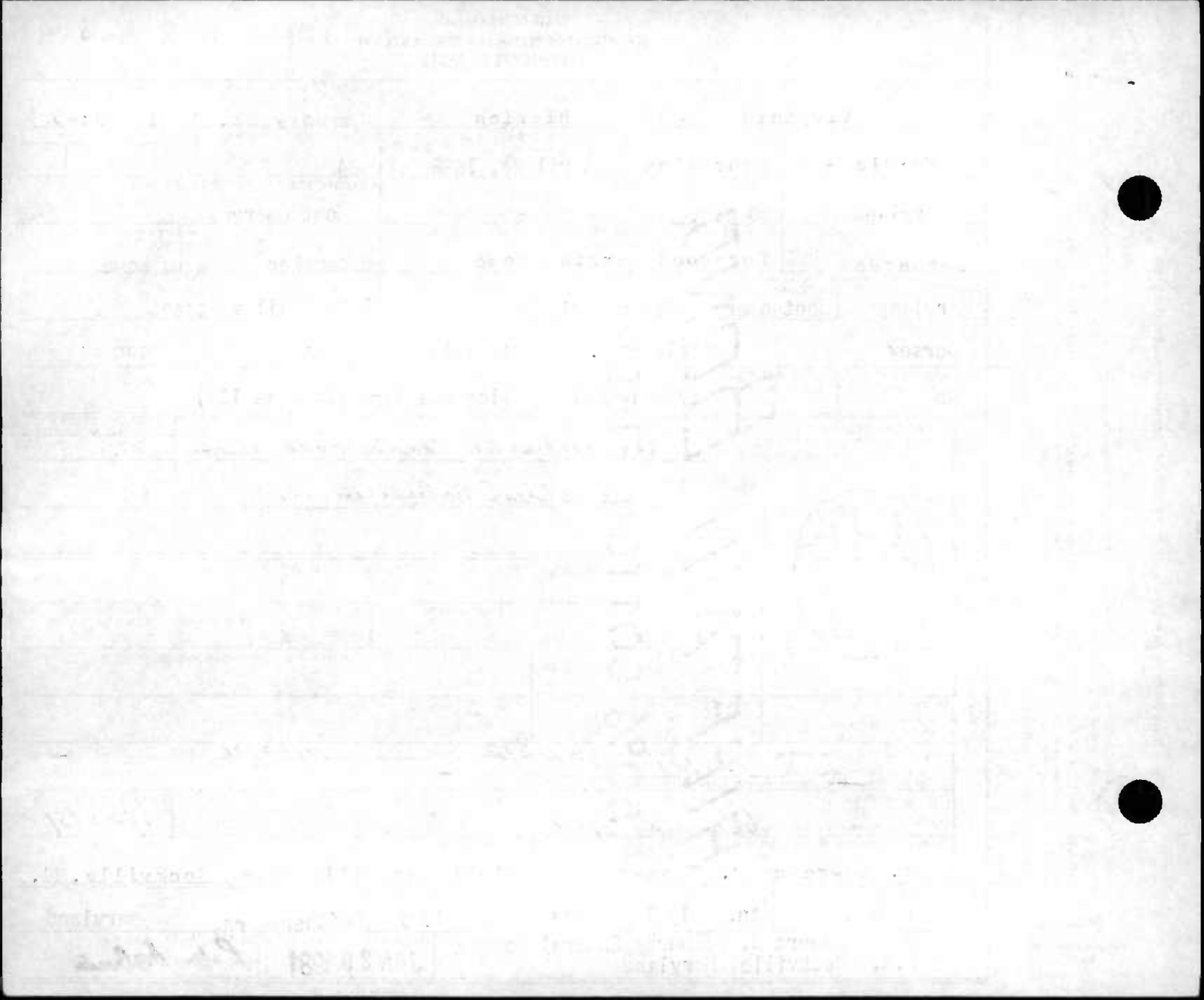
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 5 4

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Virginia A Higgins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 22, 1981 | | | 2b. HOUR
P M
9:45 | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 28, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fernwood Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dorsey Donaldson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Moon Mason | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
579-01-4691 | |
| 17. INFORMANT
ADDRESS
Alice Hoagland (Same as 13e) | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular Cardio Vasc. Disease</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
??
?? | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/13/80</u> , 19 <u>80</u> , to <u>1/23/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/8/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Lawrence J. Thomas M.D.</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/23/81</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Lawrence J. Thomas | | | 22e. ADDRESS
11801 Rockville Pike Rockville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
Jan. 26, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Gaithersburg Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
P.A., Rockville, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 5 5

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ROBERT L. HOAG | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-21-81 | | 2b. HOUR
5:54 P.M. |
| 1. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR
2 8 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Picture Framer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN
Md. Montgomery Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
508 Broadwood Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James Edward Hoag | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Dall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
U.S. Navy WWII | | 16b. SOCIAL SECURITY NO.
479-05-4579 | 17. INFORMANT ADDRESS
Gaithersburg, Md. 20760 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cardiac arrest.
5698
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial infarction
(c) Ruptured Septum Aorta | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 min
20 hrs
24 hrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Glinbladder multi fove | | | | | |
| 19a. DATE OF OPERATION
1/21/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Perforated Viscus | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-21-81 to 1-21-81 , that (1) (we) last saw the deceased alive on 1-21-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Steven Christian M.D. | | DEGREE
ATTENDING PHYSICIAN | | 22c. DATE SIGNED
1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN CHRISTIAN M.D. | | 22e. ADDRESS
334 University Blvd West Silver Spring Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1-22-81 | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. 20002 |
| 24. FUNERAL DIRECTOR NAME
Lee Funeral Home | | ADDRESS
300-4th St. N.E. Wash. D.C. 20002 | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Hofrey | |

BP



Mr. J. H. [illegible]
[illegible]
[illegible]

U.S. Navy [illegible]
[illegible]
[illegible]

1-10-51
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

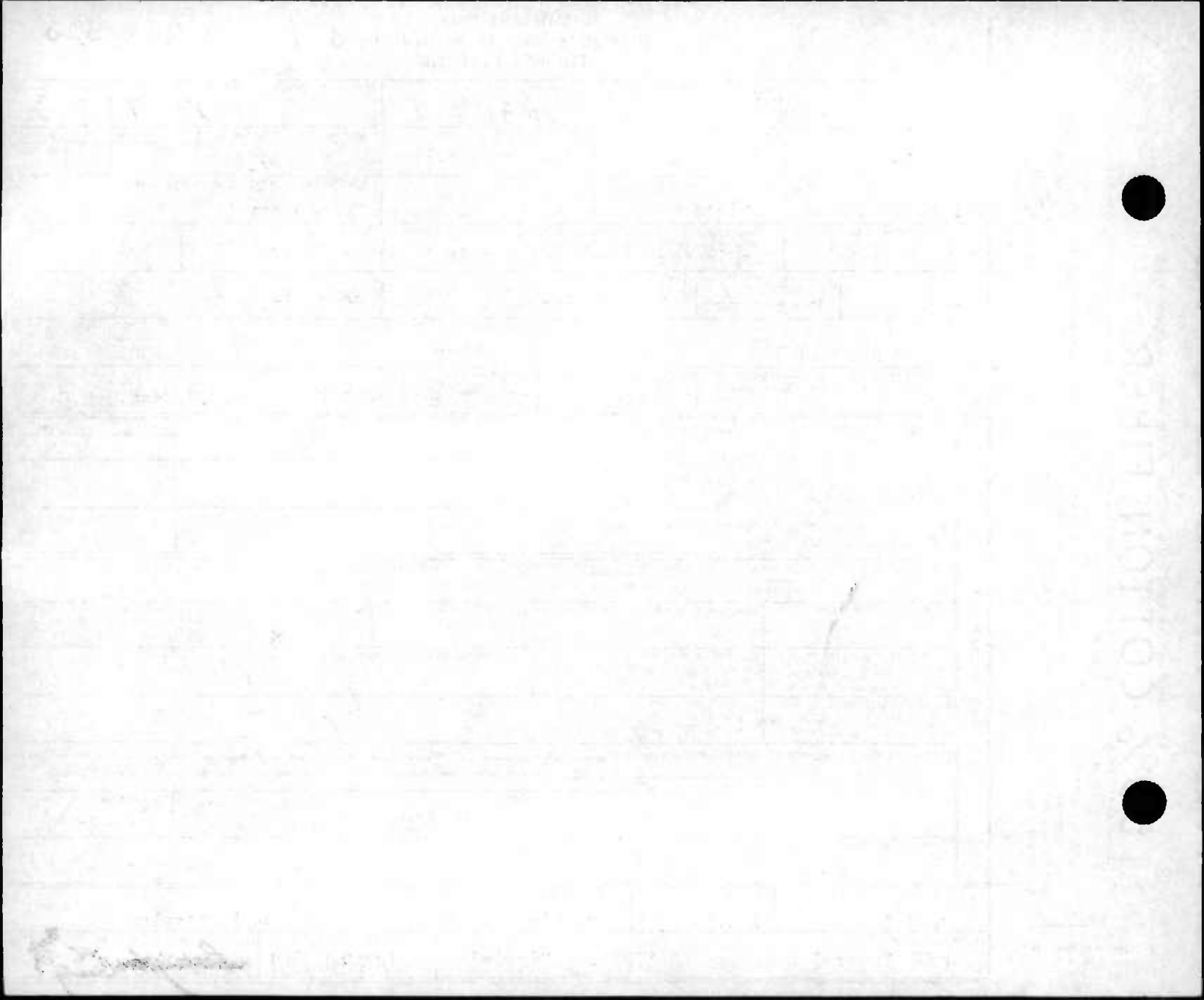
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|---------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 7 1 0 2 4 5 6 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST
RUBG HOANG | | | | | MONTH DAY YEAR
1 23 81 | | | | |
| 3. SEX
Female | | 4. RACE
Vietnamese | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 19, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 2b. HOUR
8 05 P.M. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Vietnam | | 7b. CITIZEN OF WHAT COUNTRY?
Vietnam | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9022 Linton St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tuyen D Vu | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phuc T Nguyen | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16b. SOCIAL SECURITY NO.
229-04-6339 | | 17. INFORMANT ADDRESS
Minh Hoang, 2637 Conn Ave. N.W. Wash., D.C. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>4292</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Stroke</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASCD</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Sepsis shock</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-24</u> , 19 <u>80</u> , to <u>1-23</u> , 19 <u>81</u> , that (I) (we) lost
saw the deceased alive on <u>1-23</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Michael A. Peskin</u> | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
1-24-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael A. Peskin | | | | 22e. ADDRESS
1109 Spring St Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 26, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Murphy Funeral Home Arlington, Virginia | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02457

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HARRIS HAMLIN XX HODGES | | 2a. DATE KNOWN OF DEATH ESTIMATED
Jan 13, 1981 | | 2b. HOUR
11:52 AM | |
| 3. SEX
male | | 4. RACE
Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR
2-22-05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST H | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Patent Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY
LEGAL | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
DERWOOD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
7109 ROSLYN AVE | | 14. FATHER'S NAME FIRST MIDDLE LAST
VERNON E. HODGES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA HAMLIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-38-8013 | | 17. INFORMANT
Harriet L. Hodges | | ADDRESS
Same as # 13 | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
① <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</u>
DUE TO, OR AS A CONSEQUENCE OF
② <u>PNEUMONIC CONSOLIDATION + EFFUSION</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-4 weeks
4-5 yrs
5 weeks |
| | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>FRACTURE RT. HIP - CARCINOMA LUNG - MULTIPLE SCLEROSIS</u> | | | | | |
| | | 19a. DATE OF OPERATION
12-3-80 | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
INTERTROCHANTERIC FRACTURE RT HIP |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR
P.M. 12 1 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FELL AT HOME | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY
7109 ROSLYN AVE. DERWOOD MONT MD | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | 22b. ACTUAL SIGNATURE
Francis C. Mayle | | TITLE (SPECIFY)
M.D. DEPT | | DATE SIGNED
1/14/81 | |
| 22c. EXAMINER'S NAME (TYPE OR PRINT)
Francis C. Mayle | | ADDRESS
520 Wisconsin Ave Bethesda MD | | MEDICAL EXAMINER | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jan. 15, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
Washington, D. C. | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonsville, Md. 20760 | | 25a. DATE REC'D. BY REGISTRAR
JAN 19 1981 | | 25b. REGISTRAR'S SIGNATURE | | | |

X

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Gordon V. Holahan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan 1-1981 | | 2b. HOUR
2:50 M |
| 3 SEX
Male | 4 RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
February 17, 1924 | | 6 AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b CITIZEN OF WHAT COUNTRY?
United States | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10 CITY OR TOWN OF DEATH
Potomac | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10011 Chapel Road | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Oral Surgeon | 12b. KIND OF BUSINESS OR INDUSTRY
Dentistry | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
10011 Chapel Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward C. Holahan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mavis Gordon | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | 16b SOCIAL SECURITY NO.
089-12-8490 | | 17 INFORMANT
Mary G. Holahan, Same as item #13 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma colon</u>
<u>1539</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Primary Carcinoma Colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 1/2 yrs</u>
<u>2 1/2 yrs +</u> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION
<u>April 78</u> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Carcinoma Colon</u> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>78</u> to <u>Jan</u> 19 <u>81</u> , that (I) <input checked="" type="checkbox"/> lost
saw the deceased alive on <u>Dec 15</u> 19 <u>80</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated
above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | |
| 22b. SIGNATURE
<u>James W. Egan M.D.</u> | | DEGREE
M.D. | 22c. DATE SIGNED
<u>1/1/81</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James W. Egan</u> | | 22e. ADDRESS
<u>5413 Cedar Lane 216C, Bethesda, Md.</u> | |

| | | | |
|---|-------------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
<u>January 3, 1981</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Gabriel's Cemetery</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Potomac, Maryland</u> |
| 24. FUNERAL DIRECTOR
NAME
<u>Robert A. Pumphrey</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 7 1981</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |
| <u>P.A., Bethesda, Maryland</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

ANALYSIS - 1000
ANALYSIS - 1000
ANALYSIS - 1000

ANALYSIS - 1000

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 5 9

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Helen L. Holt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/24/81 | | | 2b. HOUR
7:20 M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 17, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Librarian State Department | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rolla Berry Holt | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen Laura Bower | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 17. INFORMANT
ADDRESS
Chevy Chase, MD. | | | 18. SOCIAL SECURITY NO.
579-48-2788 | | | 19. ADDRESS
Phillip C. Holt 8105 Kerry Lane | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4140
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/24/81 to 1/24/81 , that (I) (we) last saw the deceased alive on 1/24/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John B. Umhoefer | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/24/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Umhoefer | | | 22e. ADDRESS
MD 8805 Conn. Ave. Chevy Chase | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
1981 January 26 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey | |

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 6 0

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|-----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Boyd Clyde Hooper | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 2, 1981 | | 2b. HOUR
11:33 P. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 6, 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Automobile | |
| 13a. STATE
Maryland | | 13b. COUNTY
Silver Springs | | 13c. CITY OR TOWN
Silver Springs | | 13d. STREET ADDRESS
2613 Cory Terrace | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Hooper | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie Hooper | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes Korean | | | |
| 16b. SOCIAL SECURITY NO.
242-38-3544 | | 17. INFORMANT ADDRESS
Janet W. Hooper 2613 Cory Terrace Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest & Hypotension
4360
DUE TO, OR AS A CONSEQUENCE OF (b) Brown Stem Stroke
DUE TO, OR AS A CONSEQUENCE OF (c) Poss brain Mg Seizure Stroke
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
0 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
0 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
16 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
0 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
0 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-02 19 81 to 1-02 19 81 , that (I) (we) last saw the deceased alive on 1-02-81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles H. Franklin Jr | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-03-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles H. Franklin Jr | | 22e. ADDRESS
1120 Hackwood Silver Spring Md 20901 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Thomas Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Stanley Page Va. | |
| 24. FUNERAL DIRECTOR
NAME
The Bradley Funeral Home | | ADDRESS
Luray, Va. 22835 | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1981 | | 25b. REGISTRAR'S SIGNATURE
John H. Brady | |



1961

EXHIBIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 0 2 4 6 1 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| MASON H. HOPWOOD | | | | | JANUARY 22, 1981 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 2b. HOUR | |
| Male | | Caucasian | | December 28, 1903 | | 77 YRS. | | 7 ³⁵ P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Washington, D.C. | | U.S.A. | | | | MONTGOMERY, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | SUBURBAN HOSPITAL | | Sales | | Furniture | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Montgomery | | Bethesda, | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4977 Battery Lane #714 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Thomas Hopwood | | | Elizabeth N/A | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| No | | | 577-05-3667 | | | Bethesda, Maryland | | | |
| | | | | | | Claire Porter 8207 Maple Ridge Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
<u>4960</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic obstructive pulmonary disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>35 min</u>
<u>2 weeks</u>
<u>10 yrs</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/22/81</u> to <u>1/22/81</u> , that (I) (we) lost saw the deceased alive on <u>1/22/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>John O. Allin M.D.</u> DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1.22.81</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John O. Allin M.D.</u> | | | | | 22e. ADDRESS <u>8218 Wisconsin Ave. Bethesda Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Cremation | | | January 23, 1981 | | Metropolitan Crem. | | Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</u> | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |
| | | | | | JAN 29 1981 | | | | |

THURSDAY, APRIL 17, 1958

HORWOOD

MONTGOMERY

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

STANDARD SUBURBAN MOTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with a 27-1000 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|--|--|--------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8 1 0 2 4 6 2 | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
KENNETH MICHAEL HORTON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 24 1981 | | | 2b. HOUR
0600 M | | |
| 3. SEX
MALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 29 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY)
24 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NMMC BETHESDA, MD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SONAR TECHNICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
USNR | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
ILLINOIS | | 13b. COUNTY
DEKALB | | 13c. CITY OR TOWN
MALTA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
406 S SIXTH ST | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HOWARD LA RUE HORTON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MURIEL JANILE HOPKINS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1975-1981 | | 17. INFORMANT
461-02-7782 | | Muriel Horton (Mother)
406 S SIXTH ST. DE KALB ILLINOIS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lymphoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
2028
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>DEC. 30</u> , 19 <u>80</u> , to <u>JAN. 24</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>JAN 24</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Gary Zaloga</u>
DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
24 JAN 1981 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gary Zaloga, M.D. | | | | | | 22e. ADDRESS
National Naval Medical Center Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dekalb, Dekalb Co., Illinois | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chambers Funeral Home Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony A. Crady</u> | | | |

42

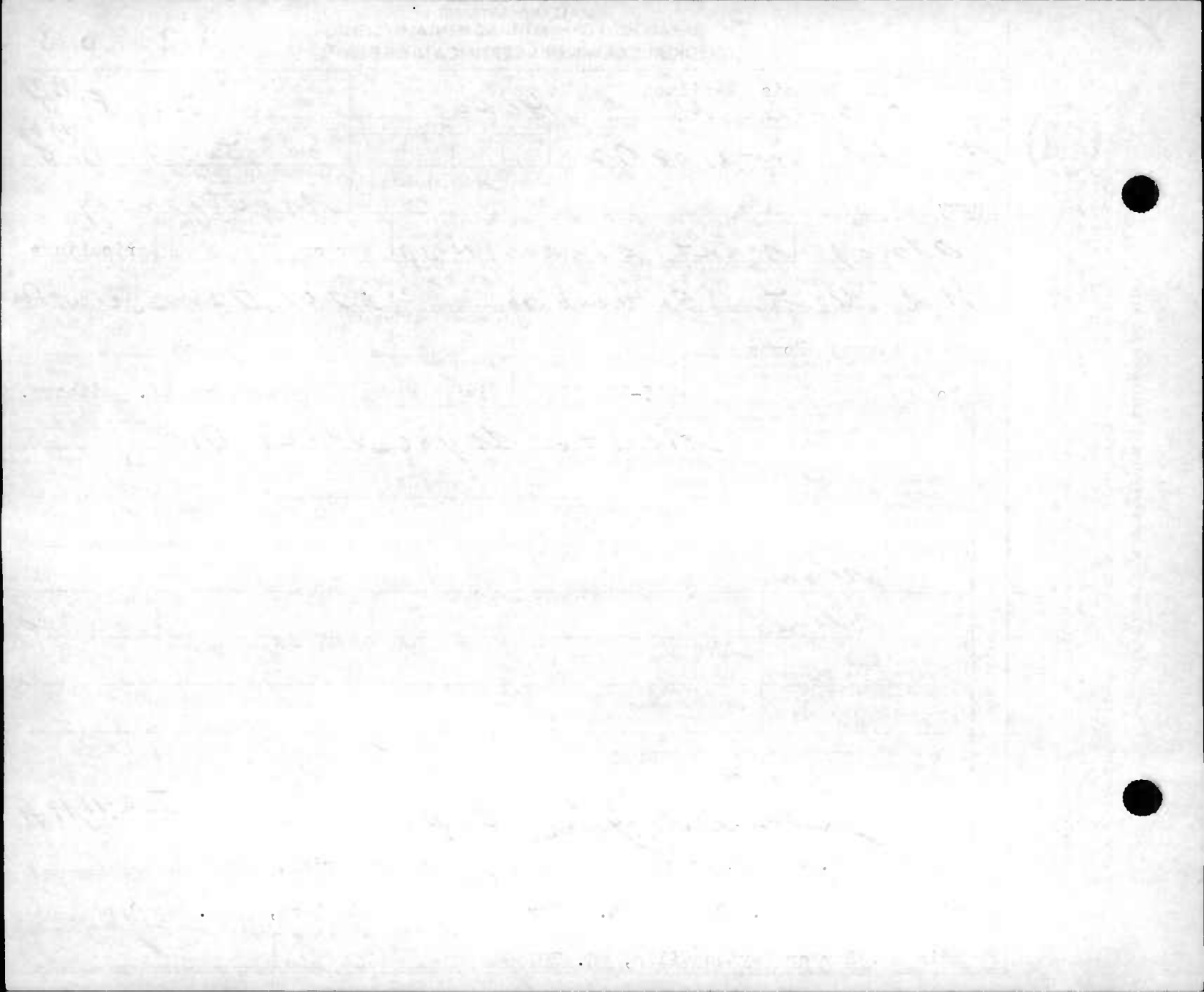
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02463

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|---------------------|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Francis Hamilton | | LAST
Howes | | 2a. DATE KNOWN
OF DEATH
ESTIMATED <input type="checkbox"/> Jan 11, 1981 | | 2b. HOUR
12:30 | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 6, 1912 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE
PRONOUNCED
DEAD
Jan 14, 1981 | 2d. HOUR
11:30 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mont. General Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Farmer | | 12b. KIND OF BUSINESS
OR INDUSTRY
Agriculture | |
| 13a. STATE
MD | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Elwood Howes | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Bowen | | 13e. STREET ADDRESS
5701 Damascus Rd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-32-1158 | | 17. INFORMANT
ADDRESS
Vivian Howes 5701 Damas cus Rd. Gaithers. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Div
DUE TO, OR AS A CONSEQUENCE OF
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL
SIGNATURE
Dr. John S. Rogers | | TITLE (SPECIFY)
M.D. Dep. | | MEDICAL EXAMINER | | DATE
SIGNED Jan 11, 1981 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS Silver Spring, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 13, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Tabor | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Etchison, Mont. Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Francis H. Barber | | ADDRESS
Laytonsville, Md. 20760 | | 25a. DATE RECEIVED
JAN 16 1981 | | REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 2 4 6 4 | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| Margaret B. Hoyle | | | | January 27, 1981 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Caucasian | | Dec. 9, 1918 | | 62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| West Virginia | | United States | | | | Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Fernwood Nursing Home | | Teacher | | Educator | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| Maryland | | | | Montgomery | | | |
| 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Bethesda | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| Charles A. Bowers | | | | Hazel M. Payne | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| No | | | | 213-44-5540 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| James T. Hoyle, Sr. (Same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) MULTIPLE Cerebral Metastases | | | | | | | 4 MRS |
| 1919 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) PRIMARY CANCER LEFT Breast | | | | | | | 4 YR JAG |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 12/76 | | Cervical Lip Biopsy | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 27, 19 81, to Jan 28, 19 81, that (I) (we) lost the deceased alive on Jan 27, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Leo I. Donovan, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 1/28/81 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | | | Jan. 30, 1981 | | Monocacy Cemetery | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | FEB 5 1981 | | [Signature] | |



1881 2 833

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 7 1 0 2 4 6 5 | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| FIRST MIDDLE LAST
Esther H. Huffman | | 1 9 81 | |
| 3 SEX | | 4 RACE | |
| Female | | Caucasian | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| 07 28 10 | | 70 YRS. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. CITIZEN OF WHAT COUNTRY? | |
| Ohio | | USA | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| Montgomery MD. | | Rockville MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Rockville N Home | | Homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? | |
| Home | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13b. STREET ADDRESS | | 14. FATHER'S NAME FIRST MIDDLE LAST | |
| 13535 Turkey Branch Pkwy. | | Bazie Step P. | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| UNKNOWN | | No | |
| 17. INFORMANT ADDRESS | | 18. SOCIAL SECURITY NO | |
| Ray E. Smith, Sr. 19446 Brassie Pl. Gaithersburg, Maryland 20760 | | 579-22-4621 | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c).
4360 CVA 2 to, Arteriosclerotic cardiovascular disease, Bilateral cerebellovascular disease, Diabetes Mellitus, asular acclussions, breast cancer | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. DATE SIGNED | |
| 21g. I certify that (I) (this hospital) attended the deceased from 19 70 to Jan 9 19 81, that (I) (we) lost saw the deceased alive on JAN 8 19 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 21h. SIGNATURE George Orr M.D. DEGREE | |
| 21i. PHYSICIAN'S NAME (TYPE OR PRINT) | | 21j. ADDRESS | |
| George Orr | | 6525 Belcrest Rd., Hyattsville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| BURIAL | | January 13 1981 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Parklawn Memorial Park | | Rockville Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE RECEIVED BY REGISTRAR | |
| Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland | | JAN 16 1981 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, mostly illegible text spanning the middle section of the page, possibly bleed-through from the reverse side.]

[Handwritten signature or initials in the bottom left corner.]

JAN 6 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 0 2 4 6 6
1981FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Thomas Anthony Hughes | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 5, 1981 | | 2b. HOUR
MIN.
6:40AM | |
| 3. SEX
male | 4. RACE
White | 5. BIRTH
MONTH DAY YEAR
March 25, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retail Clerk | 12b. KIND OF BUSINESS OR INDUSTRY
Grocery | |
| 13a. STATE
New York | 13b. COUNTY
Manhattan | 13c. CITY OR TOWN
New York | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
261 Seaman Avenue | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas - Hughes | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isabell - Jacques | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.
088-09-6087 | 17. INFORMANT
Beverly A. Cahill ADDRESS
16025 Carrs Mill Road Woodbine, Md. 21797 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
c) 10 years | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Duodenal Ulcer | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 18 Dec 1980 to 5 Jan 1981 , that (1) (we) last saw the deceased alive on 4 Jan 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not see the body after death. | | | | | | |
| 22b. SIGNATURE
 | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/5/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis Kellert, MD | | 22e. ADDRESS
18111 Prince Phillip Dr. Olney, Md. 20832 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Cremation | 23b. DATE
Jan. 6, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D. C. | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS H. BARBER LAYTONSVILLE, MD. 20760 | | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1981 | | | |
| | | | 25b. REGISTRAR'S SIGNATURE
 | | | |

69 69 69 048 3

MEDICAL CERTIFICATION

2 9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 2 4 6 7 | |
|--|---|--|--|---|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
FREDERICK FREDERICK CHARLES HOTCHINGS | | | 2a. DATE OF DEATH MONTH DAY YEAR
1/8/81 8:15 A.M. | | |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
DEC 26, 1885 | 6 AGE (IN YEARS LAST BIRTHDAY)
95 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ENGLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10 CITY OR TOWN OF DEATH
WHEATON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MANOR CARE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
DIE HARDNER | | 12b. KIND OF BUSINESS OR INDUSTRY
BUICK CO. |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALBERT HUTCHINGS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
REBECCA HUNT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
368-07-8057 | 17. INFORMANT ADDRESS
MONA B. SHULTZ SAME AS 13 DAUGHTER | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
4310
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>MASSIVE CEREBRAL HEMORRHAGE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CEREBRAL ARTERIOSCLEROSIS</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
3 DAYS
YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>SEVERE ELECTROLYTE IMBALANCE - RENAL FAILURE</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> 19 <u>78</u> , to <u>1/8/81</u> 19 <u>81</u> , that (I) (we) lost the deceased alive on <u>1/7</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Richard P. Delaney</i> | | DEGREE | | 22c. DATE SIGNED
1/8/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD P. DELANEY MD | | 22e. ADDRESS
4323 HARVARD ST SIL SPR, MD 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/10/81 | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ROCKVILLE MONT MD. |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Richard P. Delaney</i> |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
JULY 10 1900

1000

1000

1000



[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 6 8

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Thelma Elizabeth Inman</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>January 31, 1981</i> | | 2b. HOUR
<i>10 A</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Feb 10 1893</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>87 11/12</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<i>Washington, DC</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Thomas Valley Nursing Home</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>home</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
<i>Maryland Montgomery Potomac</i> | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS
<i>8700 Victory Lane</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Unknown</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>--</i> | | 17. INFORMANT ADDRESS
<i>Junius E. Inman same as 13c</i> | |

| | |
|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4871</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Influenza</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i> | |
|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|---|---|--|
| 19a. DATE OF OPERATION
<i>—</i> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>—</i> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>— P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>none</i> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>1113</i> | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>1113 19 81 to 1/29 19 81</i> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/13</i> 19 <i>81</i> , to <i>1/29</i> 19 <i>81</i> , that (I) (we) lost
saw the deceased alive on <i>1/29</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Allen J. O'Neill MD</i> | | DEGREE
<i>MD</i> | 22c. DATE SIGNED
<i>1/31/1981</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Allen J. O'Neill MD</i> | | 22e. ADDRESS
<i>8601 Old Georgetown Rd Bethesda MD</i> | |

| | | | |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>2/3/81</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington National Cemetery</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Arlington, Virginia</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland</i> | | 25a. DATE RECD. BY REGISTRAR
<i>FEB 3 1981</i> | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. *Discovered & cleared with funeral home (see)*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Montgomery

USA

Arlington, VA

Home

Rockville

8500 Victory Lane

x

Montgomery

Maryland

Unknown

Unknown

577 32 5278 Dennis E. James born on 12e

--

no

Arlington, Virginia

Arlington National Cemetery

2/3/81

SEARCHED

Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 6 9

1. FOR
STATE
REGISTRAR

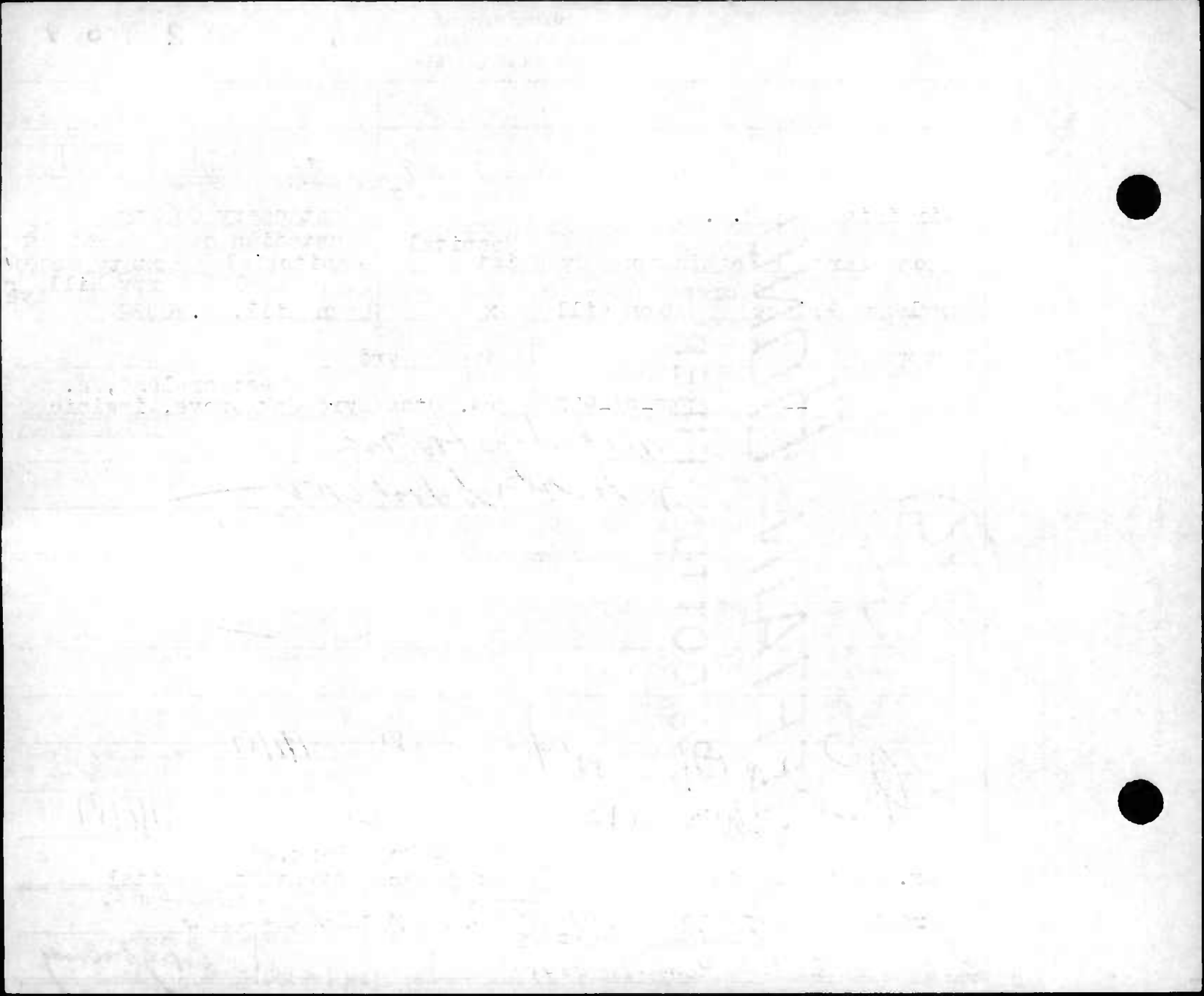
REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Cora L Jackson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 1 81 | | | 2b. HOUR
20 ⁰⁸ AM | |
| 3. SEX
F | | 4. RACE
BLK | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 7 59 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
21 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF INCOME)
Janitorial | | 12b. KIND OF BUSINESS OR INDUSTRY
Fairfax County School | |
| 13a. STATE
Maryland | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Oxon Hill | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Byrd | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
230-94-9520 | |
| 17. INFORMANT
Mrs. Otha Byrd | | ADDRESS
Westmoreland, Co.
Oak Grove, Virginia | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac mitral valve</u>
1749
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DOE TO, OR AS A CONSEQUENCE OF (b) <u>mitral valve disease</u>
DOE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (b) (this hospital) attended the deceased from <u>12/14/81</u> to <u>1/11/81</u> , that (b) (we) last saw the deceased alive or awoke (b) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Dr. Lewis Dennis</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATES SIGNED
1/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Lewis Dennis | | 22e. ADDRESS
Takoma Park, Md
Washington Adventist Hospital | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-5-81 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Littleton Oak Grove Va | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Oak Grove, Va Westmoreland Co | | 24. FUNERAL DIRECTOR
NAME
Eugene W. Lee | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1981 | |
| 25b. REGISTRAR'S SIGNATURE
Ruthy Maloney | | 25c. ADDRESS
Maryland County Card to 75 | | 25d. ADDRESS
22485 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-bonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

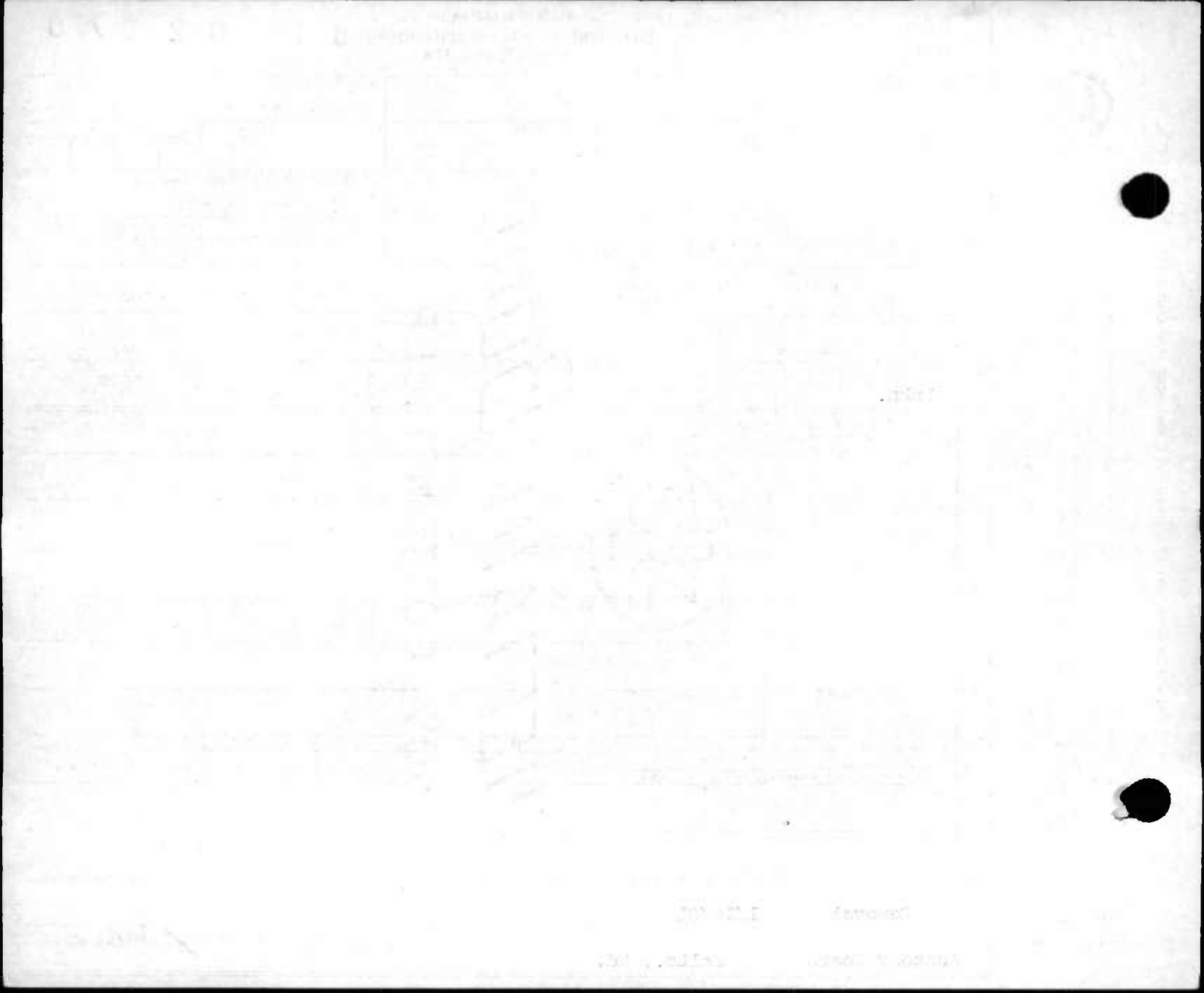
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 1 0 2 4 7 0 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Dorothy Jean Jacobs | | | | 2b. HOUR
10:45 a | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
September 15, 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
46 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda, Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
N.I.H. Clinical Center, Bethesda, Md. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland PG Laurel | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11287 Laurelwalk Drive, 20811 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Edgar F. Lambert | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret V. Proffitt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Unkn. | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
223-44-0502 | | 17. INFORMANT ADDRESS
Mr. John H. Jacobs, Husband, Address same as Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u>
1940 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metabolic Encephalopathy</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Adrenal Cortico-carcinoma</u>
4-5 months
4 years | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 16</u> , 19 <u>80</u> , to <u>January 14</u> , 19 <u>81</u> , that (X) (we) lost <u>above</u> , (X) (we) (did) (didn't) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Laurence B. Worin</i> | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1/16/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Laurence B. Worin | | | | 22e. ADDRESS
National Institutes of Health Clinical Center, Bethesda, Md. 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
1/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>P. J. McCreedy</i> | |
| ADDRESS
Balto., Md. | | | | | | | |

X 12





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 4 7 1

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Eleanor Umn Jacobs | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 21 81 | | 2b. HOUR
5³⁰ P.M. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 15, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ezra Griffith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Turner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
220-30-9534 | | 17. INFORMANT
ADDRESS
Silver Spring, Md.
Hilda McCauley, 416 Whitestone Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) prolonged comatose state
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) small cell carcinoma of lung, with metastasis to brain and adrenal glands. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
4 weeks
2 1/2 years
4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 1981 to Jan 21 1981 , that (I) (we) last saw the deceased alive on Jan 21 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Deborah Goldberg | | DEGREE
MD | | 22c. DATE SIGNED
1/22/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DEBORAH B GOLDBERG | | 22e. ADDRESS
1106 SPRING ST, SILVER SPRING, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery Hagerstown, Wash., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Rest Haven Funeral Chapel, Inc., Hag., Md. | | 25a. DATE REC'D. BY REGISTRAR
AN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert McCauley | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 7 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Mae Jaeger</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>JAN 3, 1981</i> | | 2b. HOUR
<i>1:05 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>W hite</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 17 93</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>87</i> YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Illinois</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County</i> MD. |
| 10. CITY OR TOWN OF DEATH
<i>Sil. Spg.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Benjamin Neely</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Annie Huey</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>4292 323-01-7214</i> | | 17. INFORMANT
<i>daughter</i> ADDRESS
<i>Bernice E. Evans same as 13</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
<i>4292</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arteriosclerotic Cardiovascular Disease</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 hrs.</i>
<i>10 yrs</i> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Diabetes</i> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>80</i> , to <i>Jan 3</i> , 19 <i>81</i> , that (we) last saw the deceased alive on <i>Jan 2</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Morton Altschuler</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/3/81</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Morton Altschuler</i> | | | | 22e. ADDRESS
<i>1285 Cametta Tr. Silver Spring, Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Jan. 8, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Emblem</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Elmhurst Cook Illinois</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Francis J. Collins</i> | | | | 25. DATE REC'D. BY REGISTRAR
<i>JAN 5 1981</i> | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | 25. REGISTRAR'S SIGNATURE
<i>John H. Kelly</i> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Eliminated from Illinois

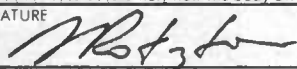

Not Investigated
Silver Springs, Md.
1971
1st Edition

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
81 02473 | |
|---|--|---|--|---|--|---|---|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Marguerite K. Johnsen | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 7, 1981 | | | 2b. HOUR
M
2:05P | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 28, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
72 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spg. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
15034 Haslemere Ct. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harold Jorgensen | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Karen Wessel | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
058-03-8592 | | 17. INFORMANT ADDRESS
William C. Johnsen 12808 N. Commons Wy. Potomac, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4254 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardiodopathy
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
DIABETES Mellitus - Pulmonary embolism | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 79 , to 1/7 , 19 81 , that (I) (we) last saw the deceased alive on Dec 17 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/7/1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alberto Rotsztain, M.D. | | | | | 22e. ADDRESS
10401 Old Georgetown Rd. Beth., Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc.
ADDRESS
5130 Wisc. Ave. N.W. Wash., D.C. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
 | | | | |

Marquette, Mich. 10/10/1911

Dear Sir,

Yours

Very truly

Yours

Very truly

John W. Wood

John W. Wood

X

Marquette, Mich.

Marquette, Mich.

Yours

Very truly

Very truly

10-10-11

10

10/10/11

John W. Wood

John W. Wood

Yours

Very truly

John W. Wood

John W. Wood

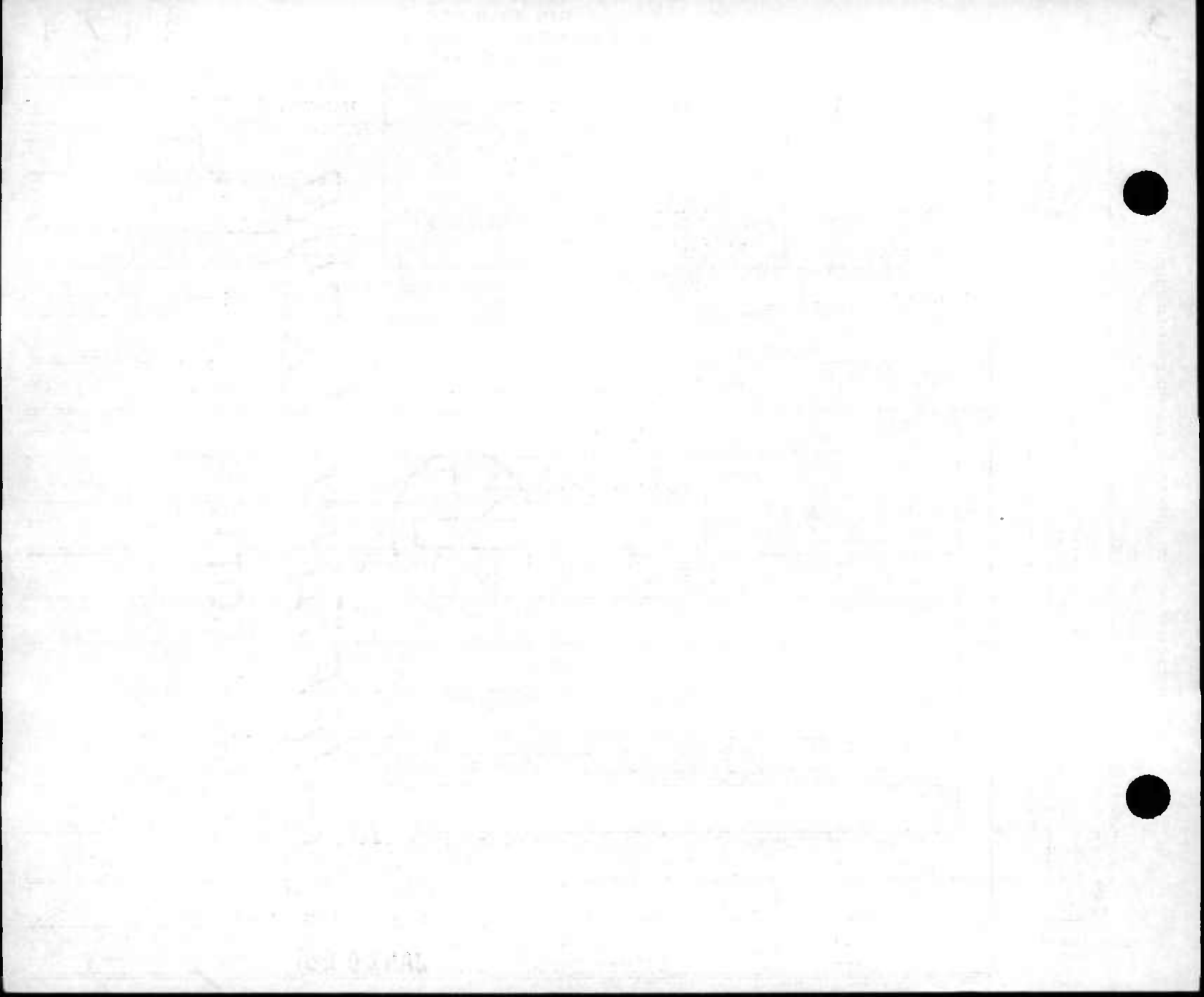
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
8 1 0 2 4 7 4 | |
|--|--|---|--|---|--|---|--|--|----------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Dale Edward Johnson | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 14, 1981 | | | 2b. HOUR
12:25 a | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 6, 1960 | | 6. AGE (IN YEARS LAST BIRTHDAY)
20 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center (NIH) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
City Employee | | 12b. KIND OF BUSINESS OR INDUSTRY
Naylor, Mo. | | | |
| 13a. STATE
Missouri | | 13b. COUNTY
Ripley | | 13c. CITY OR TOWN
Naylor | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
General Delivery 63953 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Ann Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Mrs. Ruth A. Brummund (mother) | | ADDRESS (unknown) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 2002
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Burkitt's Lymphoma | | | | | | | | | | 10 months | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Hypotension, Renal Failure, Pancytopenia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 2, 19 81 , to Jan. 14, 19 81 , that (X) (we) lost saw the deceased above , Jan. 14, 19 81 , and that in our opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Bryan J. Corden MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
1/14/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRYAN J. CORDEN | | | | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md, 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 17, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Pocahonas, Masonic Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pocahonas Randolph Ark. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi
Funeral Home | | | | ADDRESS
11800 N.H. Ave
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE
History McCreedy | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 81 02475 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DONNA LYNN JONES | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-5-81 | | 2b. HOUR
7:28 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
9-8-59 | | 6. AGE (IN YEARS LAST BIRTHDAY)
21 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY N.J. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION (IF MOST RECENT)
DENTAL ASSISTANT | | 12b. KIND OF BUSINESS OR INDUSTRY
DENTAL CLINIC | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MD | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Greenbelt | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Herbert ** Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
THYRA ** POELLOT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT NAME
Denny Franklin Jones | | | | 17. ADDRESS
5823 Cherrywood Lane, Greenbelt, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated Intravascular Coagulation</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>
0399 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-4-81 to 1-5-81, that (I) (we) last saw the deceased alive on 1-5-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. M. Abdullah M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1/6/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sofia Abdullah, Md | | | | 22e. ADDRESS
6215 Greenbelt Rd Suite 303 College Park Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore P.G. Md. | |
| 24. FUNERAL DIRECTOR
Richard A. Coleman - Upper Marlboro, Maryland 20870 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
Ricky McHenry | |

MEMORANDUM FOR THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Eleanor Rose Jones | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 11, 1981 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 14, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Arizona | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sylvan Manor Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
2700 Barker St. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Claude Decatur Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie Alice Cox | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
579-18-7783 | | 17. INFORMANT ADDRESS
The Rev. Benjamin Lynt, Alexandria, Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
2500
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterioscleotric Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immed.
Yrs.
yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Schizophrenia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1975 , 19, to 1/11/ , 19 81 , that (I) (we) lost
saw the deceased alive on 12/20/80 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
Jeremy V. Cooke | | | | 22c. DATE SIGNED
1/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeremy V. Cooke | | | | 22e. ADDRESS
10400 Conn Ave., Kensington, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1/12/81 | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. |
| 24. FUNERAL DIRECTOR
NAME
Cunningham Funeral Home, Inc. | | ADDRESS
Alex. Va. Cameron & Alfred | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Patricia K. Bundy | |

11

20% COIL

1941 12 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 81 02477 | | | | | |
|--|--|------------------------------|--|--|--|--|--|---|----------------------------|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | MONTH DAY YEAR | | | | | |
| Mamie Tripp Jones | | | | Jan 17 1981 | | | | 8:35 AM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | | | |
| Female | | White | | MONTH DAY YEAR | | 94 YRS | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | | | Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | | | Rockville Nursing Home | | | | Housewife | | | | Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 263 Congressional Lane Apt. 306 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| John Tripp | | | | Elizabeth Peters | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | | | 213-74-7094 | | Marguerite Hartman | | 125 S. VanBuren Street Rockville, Maryland 20850 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> | | | | | | | | | | | | | |
| 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Old Age</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>June</i> 19 <i>80</i> to <i>Jan 17</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>10/28</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <i>Carol L Bender</i> | | | | | | | | 1/17/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| Dr. Carol L. Bender | | | | 11510 Old Georgetown Rd., Rockville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | | | 1/19/81 | | Cedar Hill Cemetery | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | Suitland Prince George's Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25. DATE RECEIVED BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| NAME Tyson Wheeler Funeral Home | | | | | | 1331 Rockville Pike, Rockville, Maryland 20852 | | | JAN 20 1981 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8102478 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|---|--|--|---|--|--|--------------------------------|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 05 81 | | | | | | | 2b. HOUR 8:10 P.M. | | | | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
GOPAL C. JOSHI | | | | | 3 SEX MALE | | | | | 4 RACE INDIA | | 5. DATE OF BIRTH MONTH DAY YEAR JAN 26 1903 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 14 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIA | | | | | 7b. CITIZEN OF WHAT COUNTRY? INDIA | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDIA GOVT. EMPLOYEE | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. STATE MD | | | | | 13b. COUNTY MONT | | | | | 13c. CITY OR TOWN SILVER SPRING | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS 1217 BURTIN STREET | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST B. D. JOSHI | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GANGA PANT | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 220-92-9506 | | | | | 17. INFORMANT ADDRESS HANSA JOSHI, 1217 BURTIN ST. S.S. MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reproductive Failure & Shock | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS. | | | | | | | | | | | | | | |
| 4824 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) COPD, Pneumonia | | | | | | | | | | 10 days | | | | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF STAPH AUREUS, Klebsiella | | | | | | | | | | 10 days | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Liver failure, Hepatorenal syndrome | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 1980 to now, 1981, that (I) (we) last saw the deceased alive on 11/27/80, and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | DEGREE | | | | | 22c. DATE SIGNED 1/6/81 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. GALOTTI MD | | | | | 22e. ADDRESS 5225 ROCKS HILL RD, Bethesda | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | | | 23b. DATE Jan. 7 1981 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BETHESDA MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR [Signature] | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1981 | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | |

3

06-11-2007

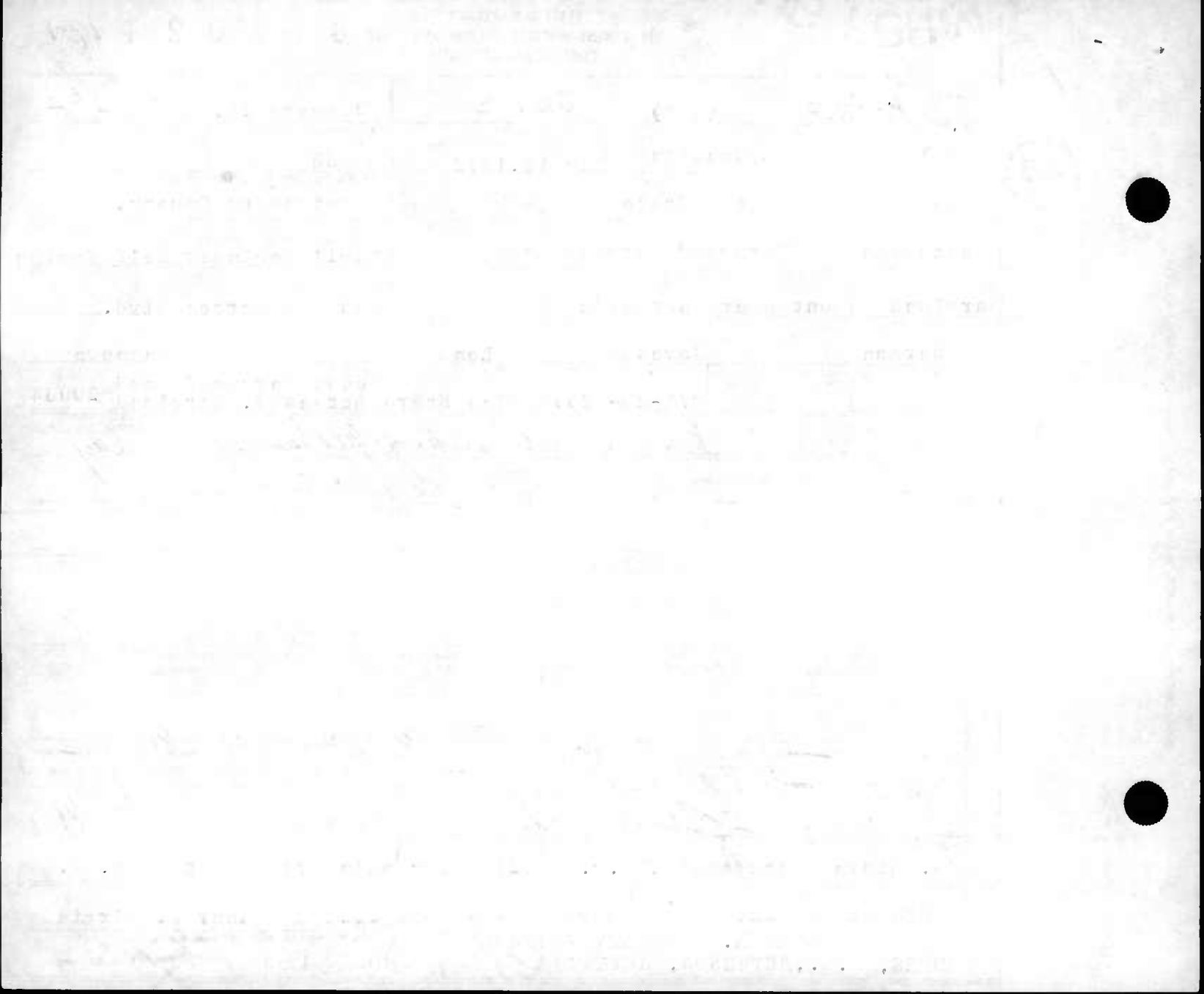
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

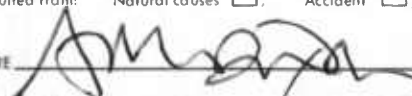

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8102479 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Arthur (NMI) Jovis | | | | 2b. HOUR 2:15 A.M. | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
May 19, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fernwood Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Civil Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employed | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Herman Joveshof | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lena unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
071-20-7257 | | 17. INFORMANT ADDRESS
Helen Stern Bethesda, Maryland 20034 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
4310 IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF
Cerebral Hemorrhage - left hemisphere
Chronic Arteriosclerotic Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) }
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Day | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the physician) attended the deceased from June 17, 1980 to January 21, 1981, that (I) (last) saw the deceased alive on January 20, 1981, and that in (my) (best) opinion death occurred on the date and hour and from the causes stated above (I) (did) (did not) (the body) after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald, M.D. | | | | 22c. DATE SIGNED
1/21/81 | | 22d. ADDRESS
8218 Wisconsin Avenue Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jan. 22, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE
R. J. McCurdy | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02480 | |
|--|--|-------------------------|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ROBERT T. JUDDY, II | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>
MONTH DAY YEAR
1 16 1981 | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 28 1944 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
36 YRS. | | IF UNDER 1 YR. MONTHS DAYS
36 | | 2b. HOUR
4:14 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1 16 1981 | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Under Bridge of Rt. 355 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrical | |
| 13a. STATE
MD. | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18604 Phoebe Way | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank E. Juddy | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phyllis M. Eddy | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO - | | | |
| 16a. SOCIAL SECURITY NO.
217-42-2174 | | | | 17. INFORMANT
Mrs. Phyllis Juddy Gaithersburg, Md. 20760 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR
3-4 P.M. 1-16- 1981 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject jumped from bridge. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bridge | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 355 Gaithersburg, Montgomery, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
1-17-81 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Jan. 20, '81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | 23d. LOCATION
CITY OR TOWN STATE
Suitland Prince Georges Md. | |
| 24. FUNERAL DIRECTOR
Gartner Sandison F.H. Gaithersburg, Md. | | | | 25a. DATE RECEIVED BY REGISTRAR
JAN 21 1981 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | |

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02481

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mollie M. Kamins | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jan 10 19 81 | | | 2b. HOUR OF DEATH 10:00 AM | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR May 1, 02 28 YRS | 6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD Jan 10 19 81 | 7d. HOUR OF DEATH 10:00 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH 511 Spg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY School |
| 13a. STATE Ill | | | 13b. COUNTY Cook | 13c. CITY OR TOWN Chicago | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 4800 Chicago Beach Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Moishe Eli Mailick | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Shiner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. --- | | 17. INFORMANT ADDRESS Clive Kamins, Homewood, Illinois | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
8809 IMMEDIATE CAUSE (a) Cerebral Trauma
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Head Injury
(c) Fall | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 days
14 days
14 days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | |
| 19a. DATE OF OPERATION None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 1227 80 | | | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 12 27 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell down stairs | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2838 Westchester Dr Spg Md | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | TITLE (SPECIFY) Deputy M.E. | | | DATE SIGNED Jan 10/981 | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D. | | | ADDRESS Deputy M.E. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-12-81 | 23c. NAME OF CEMETERY OR CREMATORY Oak Woods Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Chicago, Illinois | |
| 24. FUNERAL DIRECTOR Danzansky-Goldberg Chapels | | | | 25a. DATED BY REGISTRAR Jan 10 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |
| NAME 1170 Rockville Pike; Rockville, Md. | | | | ADDRESS | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 4 8 2 | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Irving</i> <i>nmn</i> <i>Karabell</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1. 16. 81</i> | | | | 2b. HOUR <i>2:41 A.M.</i> | | | |
| 3 SEX <i>MALE</i> | | 4 RACE <i>CAUCASIAN</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>OCT. 25 1910</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PHILADELPHIA</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH <i>TAKOMA PK.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASH. ADVENTIST HOSP.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>GROCER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>FOOD.</i> | | | |
| 13a. STATE <i>MD.</i> | | | | 13b. COUNTY <i>MONT.</i> | | 13c. CITY OR TOWN <i>SIL. SPR.</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>8715 1st AVE.</i> | |
| 14 FATHER'S NAME FIRST <i>JACOB</i> MIDDLE <i>---</i> LAST <i>KARABELL</i> | | | | 15 MOTHER'S MAIDEN NAME FIRST <i>IDA</i> MIDDLE <i>---</i> LAST <i>GOLDBLAT</i> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>160-03-9544</i> | | | | 17 INFORMANT ADDRESS <i>11408 MONTICELLO AV. MR. MAURICE DUNIE SILVER SPRING MD.</i> | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>6000</i> IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>---</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>1/12/81</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Brain tumor - hyperostosis</i> | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NAME MEDICAL EXAMINER) <i>---</i> | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>---</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>---</i> | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>---</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>---</i> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/12</i> 19 <i>81</i> , to <i>1/16</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>1/15</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Irving W. Wicks</i> | | | | DEGREE <i>---</i> | | | | 22c. DATE SIGNED <i>1/16/81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A.J. WICKS</i> | | | | 22e. ADDRESS <i>1111 Spring St. Silver Spring Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | | | 23b. DATE <i>1-18-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>FALLS CHURCH VA.</i> | | | |
| 24 FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG</i> | | | | ADDRESS <i>1170 Rockville Rd. Rockville, Md.</i> | | | | 25a. DATE REC'D BY REGISTRAR <i>JAN 20 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>---</i> | |

NEW YORK

NEW YORK

JAN 1 1895

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 8 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|--|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Hannah A. Kay | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 31 81 | | 2b. HOUR
9:05 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 17, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retail Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Variety Stor |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil Spg. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leopold Solomon | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mollie (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
188-01-3314 | | 17. INFORMANT ADDRESS
Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Pneumonia, Acute
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Brain Syndrome
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 WEEKS
LONG STANDING
" | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-19 , 19 80 , to 1-31 , 19 81 , that (I) (we) last saw the deceased alive on 1-31 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
John B. Nabou, MD | | | | DEGREE ASSOCIATE OF
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-31-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN B. NABOU, MD | | | | 22e. ADDRESS
200 BERTHOLD DR.
SILVER SPRING, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-2-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Nat'l. Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1981 | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | |

75
71
35
50
1

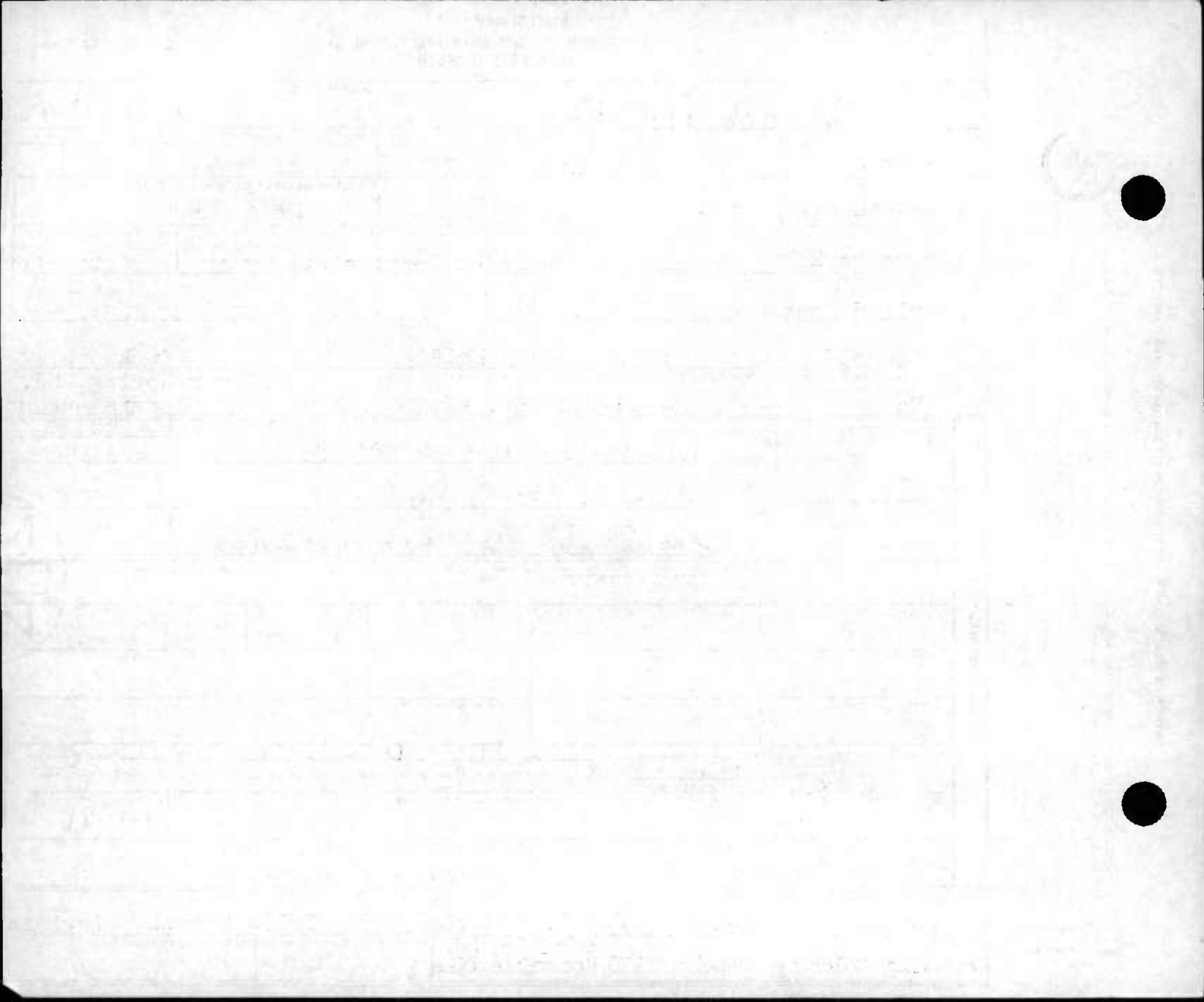
2
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

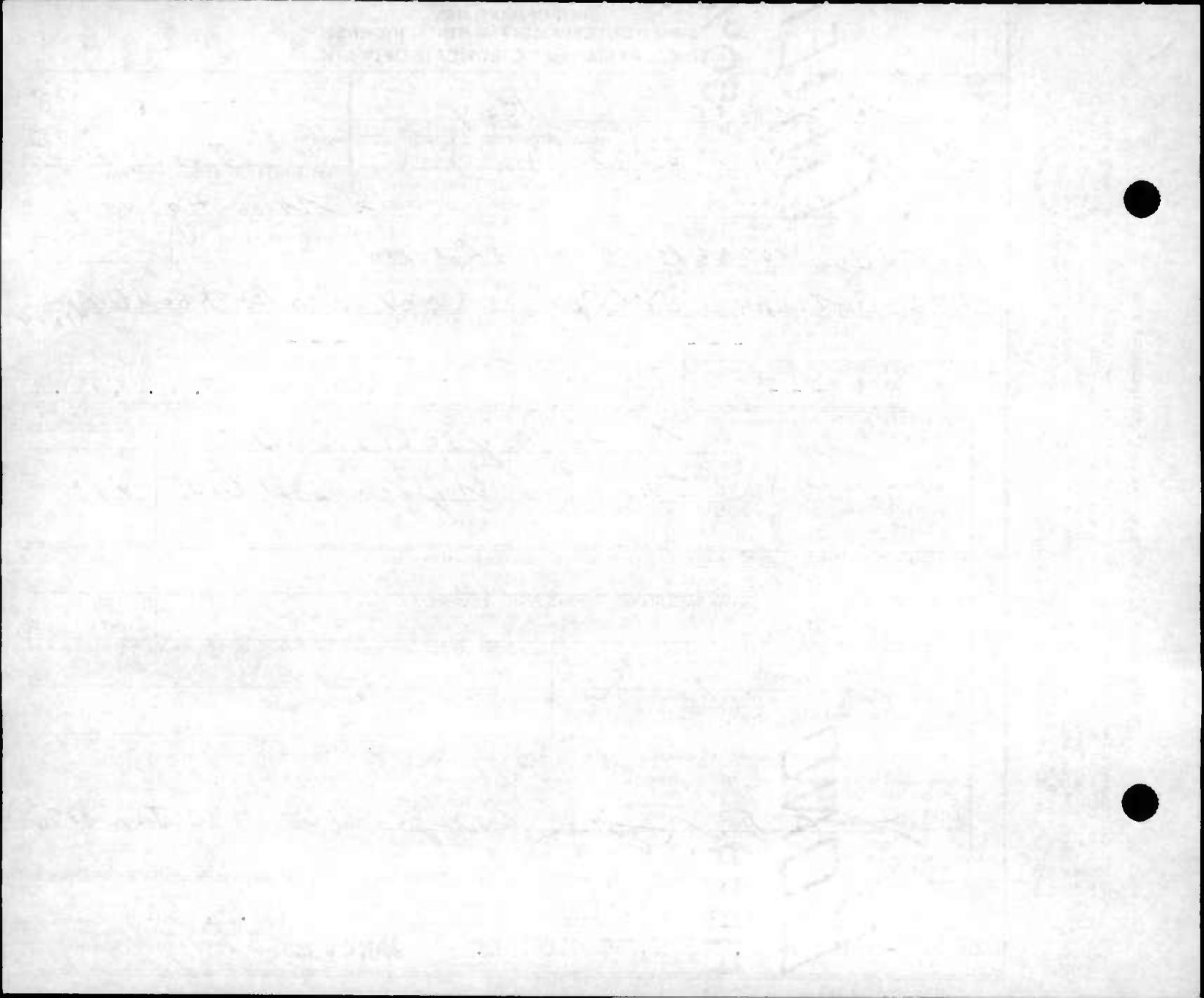
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02484

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|--|---|---|------------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Maurice Kay | | | 2a. DATE KNOWN OF DEATH
ESTIMATED Jan 18 1981 | | | 2b. HOUR
3:00 P.M. | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
Apr. 20 05 25 | 6. AGE (IN YEARS)
LAST BIRTHDAY
25 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
Jan 18 1981 | 2d. HOUR
3:00 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silksprg. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10906 Bucknell Dr. Apt 1224 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
REAL ESTATE | | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silksprg. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PHILLIP - - - KAY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE - - - LENKIN | | 16. SOCIAL SECURITY NO.
(unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- - - | | 17. INFORMANT ADDRESS
HAROLD GREENBERG, 4200 MASS.AVE.NW, WASH.DC | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4391 IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c) Yrs. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
John P. D. [Signature] | | TITLE (SPECIFY)
M.D. Dep. | | | | DATE
Jan 18 1981 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/22/81 | | 23c. NAME OF CEMETERY OR CREMATORY
ADAS ISRAEL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALABAMA AVE. SE, WASHINGTON, DC | | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1981 | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |



Item 17 g552 2/24/81 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 8 5

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. STATE REGISTERED | | Milada Kazda | | 20. DATE OF DEATH | | MONTH DAY YEAR | | 20. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 19 81 | | 6 25 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | | White | | June 19, 1890 | | 90 | | Montgomery MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Czechoslovakia | | US | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | Washington Adventist Hospital | | Seamstress | | Self-employed | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| | | Md. | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 16c. INTERMENT ADDRESS | |
| Jan | | Anna | | No | | 069-30-8145 | | Smetacek Same as item # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): | | 5990 | | Acute Respiratory Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b): | | Congenitive Cardiac Failure | | | | | |
| (c): | | Urinary Tract Infection | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | Atherosclerotic Heart Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16: PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| | | Dr. V. Vaid, M.D. | | | | 1/19/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Dr. V. Vaid, M.D. | | 7676 New Hampshire Ave. Langley Park, Md. | | Cremation | | 1/21/81 | | Cedar Hill Crematory Suitland, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Joseph Gawler's Sons, Inc. | | JAN 26 1981 | | History McBrady | | | | | |
| 5130 Wisc. Ave. N.W. Wash., D.C. | | | | | | | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• 9V • 1502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

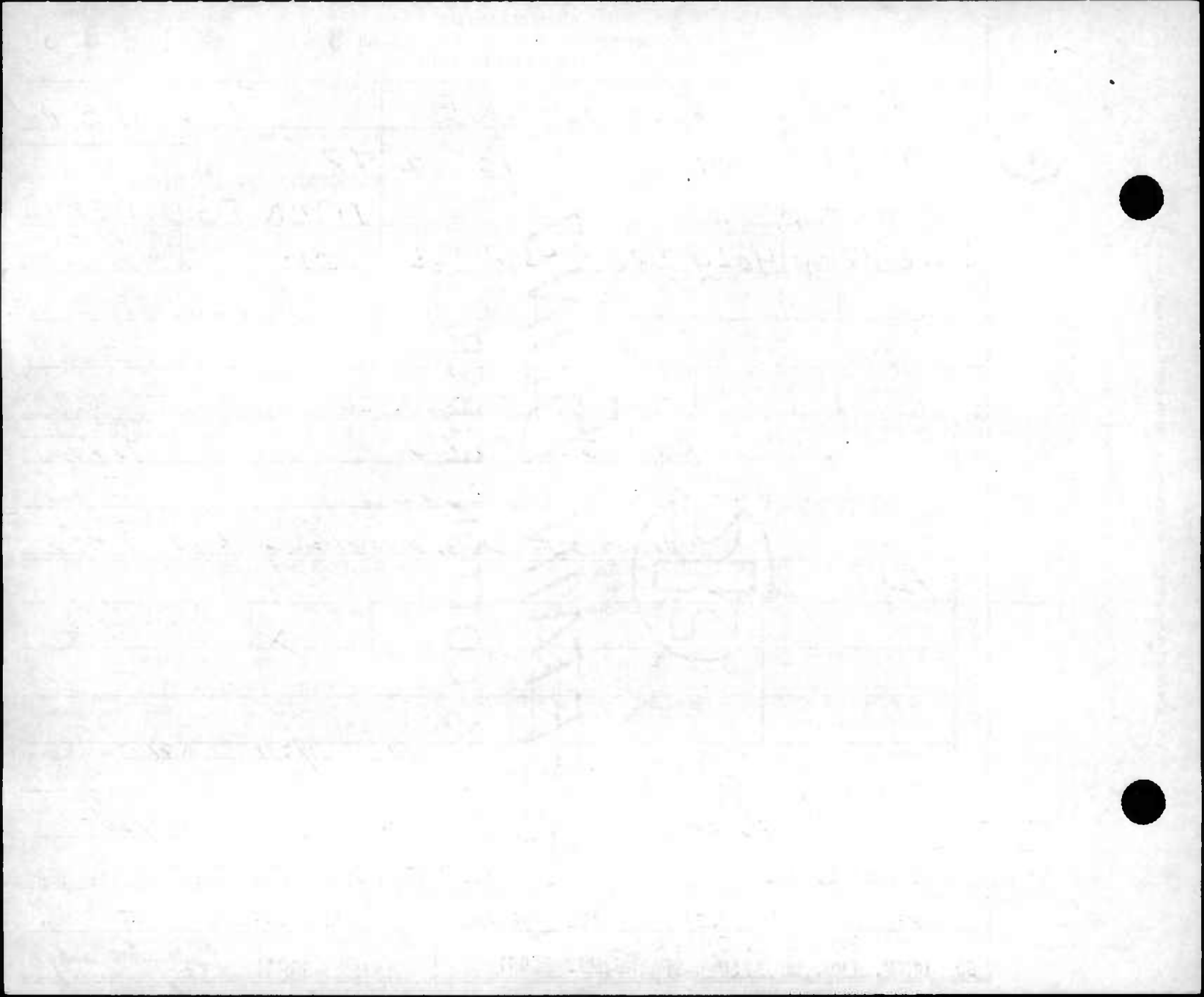
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HENRY E. KEANE | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-20-81 | | 2b. HOUR
5 P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 12 02 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FOREMAN | |
| 12b. KIND OF BUSINESS OR INDUSTRY
RAILWAY EXPRESS | | 13a. STATE
N/A | | 13b. COUNTY
N/A | |
| 13c. CITY OR TOWN
WASHINGTON, D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4819 S. DAKOTA AVENUE, N.E. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN J. KEANE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET O'CONNOR | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
714-07-8790 | | 17. INFORMANT
BERNICE G. KEANE | |
| 17. ADDRESS
SAME AS 13 | | 18. WIFE
WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Longstanding Heart Failure
(c) Arteriosclerotic Cardiovascular disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)
Renal failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 19 77 , to 1/20 , 19 81 , that (I) (we) lost
saw the deceased alive on 1/20 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Ernest S. Oser | | DEGREE
MD. | | 22c. DATE SIGNED
1/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERNEST S. OSER | | 22e. ADDRESS
10301 GEORGIA AVENUE, SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1

0 2 4 8 7

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HELEN CANNON KENNER | | 2a. DATE OF DEATH MONTH DAY YEAR
10 JAN 1981 | | 2b. HOUR
1:30 PM | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH MONTH DAY YEAR
16 NOV 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NNMC BETHESDA, MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
N. CAROLINA | | 13b. COUNTY
RICHMOND | | 13c. CITY OR TOWN
HAMLET | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
FELIX CANNON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELEANOR LUCAS | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
225-34-0140 | | 17. INFORMANT Wm. W. Kenner ADDRESS
407 CHARLOTTE ST. HAMLET, N. CAROLINA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
1991
IMMEDIATE CAUSE (a) METASTATIC SQUAMOUS CELL C.A.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 December , 19 80 , to 10 January , 19 81 , that (I) (we) last saw the deceased alive on 10 January , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Frederick N. Meyer, MD</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12 JAN 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederick N. Meyer | | 22e. ADDRESS
NNMC Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Trinity Episc. Ch. Cen. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Edisto Island, S. C. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME 5130 Wisc. Ave. N.W. Wash., D.C. 20016 ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Patricia Kennedy</i> | |

BP

RECEIVED
JAN 1 1981

Montgomery

Homestead

X

Mr. W. L. Turner



5250 Rice Ave. N.W. Seattle, W.A. 98105
Loren H. Gavel's Home, Inc.
JAN 1 1981
Fidelity Investments

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 2 4 8 8
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|------------------|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div> <div style="display: flex; justify-content: space-between;"> BEN KESSLER </div> | | | | | | | | | | <div style="display: flex; justify-content: space-between;"> MONTH DAY YEAR </div> <div style="display: flex; justify-content: space-between;"> JAN 25 81 </div> | | <div style="display: flex; justify-content: space-between;"> 11²⁵ AM </div> | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | <div style="display: flex; justify-content: space-between;"> MONTH DAY YEAR </div> <div style="display: flex; justify-content: space-between;"> March 6, 1902 </div> | | 78 | | YRS. | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Poland | | U. S. A. | | | | MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | |
| ROCKVILLE | | HEBREW HOME OF GREATER WASHINGTON | | | | | | | | | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12c. KIND OF BUSINESS OR INDUSTRY | |
| <div style="display: flex; justify-content: space-between;"> 13a. STATE 13b. COUNTY 13c. CITY OR TOWN </div> <div style="display: flex; justify-content: space-between;"> Maryland Montgomery Rockville </div> | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | |
| <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div> <div style="display: flex; justify-content: space-between;"> Samuel Kessler </div> | | | | | | | | | | <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div> <div style="display: flex; justify-content: space-between;"> Sylvia Green </div> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | |
| No | | 577-09-7419 | | <div style="display: flex; justify-content: space-between;"> 801 Wrettington Terrace Silver Spring, Maryland </div> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> | | | | | | | | | | 1 WEEK | | | |
| <div style="display: flex; justify-content: space-between;"> 3320 DUE TO, OR AS A CONSEQUENCE OF </div> <div style="display: flex; justify-content: space-between;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PARKINSONISM</u> </div> | | | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> (c) <u>DEMENTIA</u> </div> | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | <div style="display: flex; justify-content: space-between;"> HOUR A.M. MONTH DAY YEAR </div> <div style="display: flex; justify-content: space-between;"> P.M. 19 </div> | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> </div> | | <div style="display: flex; justify-content: space-between;"> AT HOME, STREET, FACTORY, OFFICE, FARM, ETC. </div> | | <div style="display: flex; justify-content: space-between;"> STREET CITY OR TOWN COUNTY STATE </div> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 25, 1981</u> to <u>1/25/81</u> , that (I) (we) lost the deceased alive on <u>Jan. 25, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <div style="display: flex; justify-content: space-between;"> MD. </div> | | | | <div style="display: flex; justify-content: space-between;"> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> </div> | | | | 1/25/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| D. D. PATEL | | | | 6121 MONTROSE RD, Rockville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION | | | | | | | |
| Burial | | 1/26/1981 | | Ohev Sholom Talmud Torah | | <div style="display: flex; justify-content: space-between;"> Washington, D. C. </div> | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> NAME ADDRESS </div> <div style="display: flex; justify-content: space-between;"> Donald M. Stein Hebrew Memorial F.H. </div> | | | | | | | | | | | | | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| JAN 29 1981 | | | | <div style="display: flex; justify-content: space-between;"> </div> | | | | | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

BEN

KESSLER

JAN 21 1981

MONTGOMERY

ROCKVILLE

ST. LOUIS

MEMPHIS

ATLANTA

CHICAGO

MIAMI

ATLANTA

ATLANTA

(1981 JAN 21)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 2 4 8 9 | |
|---|-------------------------|--|--|--|-----------------------------|
| FOR
1 - STATE
REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Grace Bell King</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>January 13 1981</i> | | 2b. HOUR
<i>12 45 PM</i> |
| 3 SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR <i>Sept 11 1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>85</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hosp.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired-pat offc</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Sp.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Louis B King</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Emma J Hurley</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
<i>Dorothy Boyden 3317 Highwood Dr S.E/
Washington, D.C.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>
<i>4409</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Atherosclerosis Respiratory Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Renal insufficiency. Upper GI bleeding. Acute Hypertension. Myocardial infarction. Double vision.</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January 13</i> , 19 <i>81</i> , to <i>January 13</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>January 13</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Hugo G. Graziani MD</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1-13-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Hugo G. GRAZIANI</i> | | 22e. ADDRESS
<i>605 Parkview Dr. 303A
S. S. Md. 20910</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Jan 16 81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft Lincoln Cem</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Robert E Wilhelm Funeral Home
Suitland Maryland</i> | | 25a. DATE AND BY REGISTERED
<i>JAN 19 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Brentwood Maryland</i> | | | | | |

MEDICAL CERTIFICATION

2900 BP

4

TO: SAC, ALBUQUERQUE
FROM: SAC, DENVER
SUBJECT: [Illegible]

Re Denver letter to Albuquerque dated 10-10-40.

Enclosed for the Albuquerque office are two copies of a letterhead memorandum from the Denver office to the Albuquerque office dated 10-10-40.

The letterhead memorandum contains information regarding the [Illegible] of the [Illegible] in the [Illegible] area.

The letterhead memorandum also contains information regarding the [Illegible] of the [Illegible] in the [Illegible] area.

The letterhead memorandum is being furnished to the Albuquerque office for your information and for your use in the [Illegible] of the [Illegible] in the [Illegible] area.

The letterhead memorandum is being furnished to the Albuquerque office for your information and for your use in the [Illegible] of the [Illegible] in the [Illegible] area.

The letterhead memorandum is being furnished to the Albuquerque office for your information and for your use in the [Illegible] of the [Illegible] in the [Illegible] area.

Very truly yours,
[Illegible Signature]
Special Agent in Charge

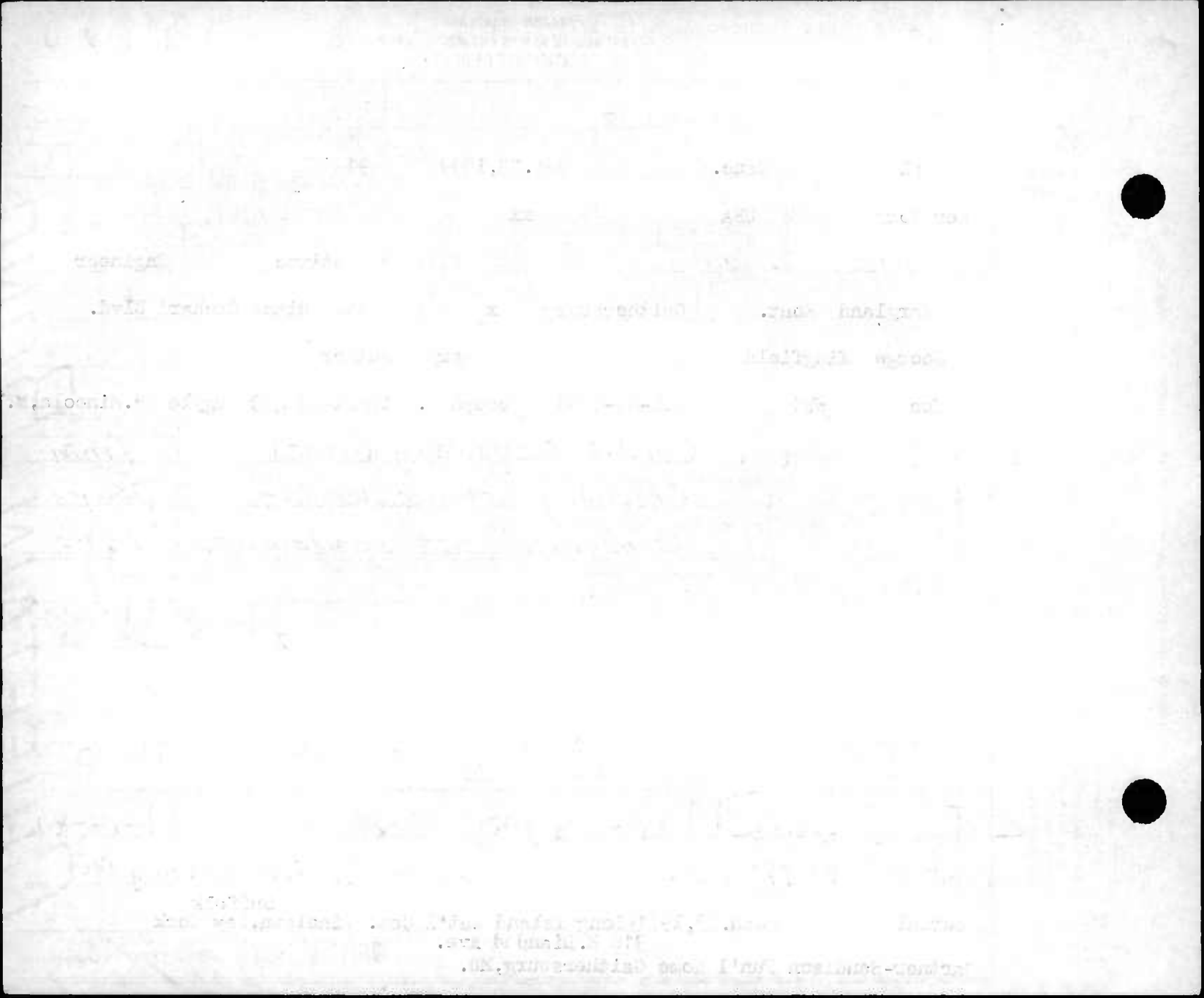
item 6 per phone call w/fh 1/17/81
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

81 02490

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph F. Kingfield | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 14 1981 | | | 2b. HOUR
0455 | | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 23, 1899 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Engineer | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
714 Quince Orchard Blvd. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Kingfield | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Butler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW1 | | 16b. SOCIAL SECURITY NO.
062-03-7003 | | 17. INFORMANT ADDRESS
Joseph P. Kingfield 483 Argyle Rd. Mineola, N. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Cardio-respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 min
10 yrs
15 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Myocardial infarction | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 19 80 , to Jan 14 19 81 , that (II) (we) lost Jan 13 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
James R. Moore Jr. | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1-14-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. | | | | 22e. ADDRESS
207 Brookes Ave Gaithersburg MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 19, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Long Island Nat'l Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suffolk Pinelawn, New York | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Gartner-Sandison Fun'l Home Gaithersburg, Md. | | | | 25a. DATE OF REGISTRATION
JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE
Notary Public | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

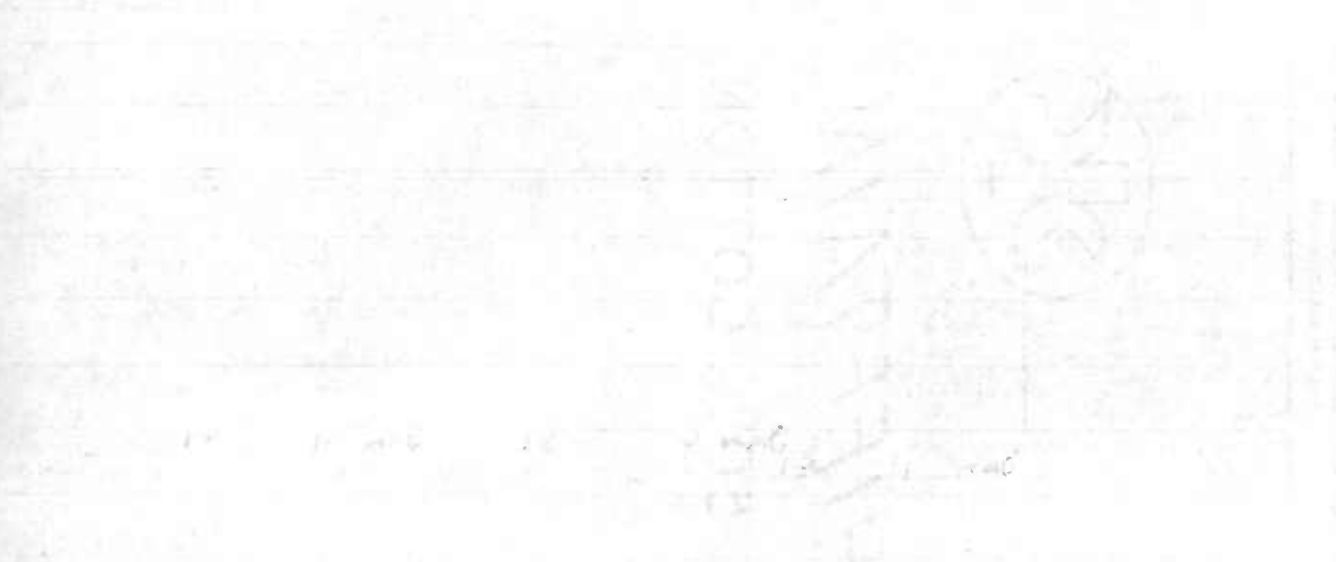
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 02491 | |
|---|--|--|--|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Maude Kennedy | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/11/81 | | | 2b. HOUR
11:50 AM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 6 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tenn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5100 Acacia Ave | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William B Silliman | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Kate McCain | | | ADDRESS 5100 Acacia Ave Bethesda Md 20014 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Frances Millican | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEART + RESPIRATORY FAILURE
1541
DUE TO, OR AS A CONSEQUENCE OF
(b) PERFORATED RECTAL TUMOR (CARCINOMA)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
8 JAN. 81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
PERFORATED RECTAL CARCINOMA | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 6 19 81 to JAN 11 19 81 , that (I) (we) lost saw the deceased alive on JAN 11 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J.R. Thistlethwaite M.D. by Ann Robinson DEGREE MD | | | | | | | | 22c. DATE SIGNED
12 Jan. 81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.R. Thistlethwaite M.D. | | | | 22e. ADDRESS
10401 Old Georgetown Rd, Bethesda Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
JAN. 16, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Flowerance Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Flowerance Lauderdale Ala | | 23e. DATE OF REGISTRATION
JAN 16 1981 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.W. Chambers Colma Silver Spring Md | | | | | | | | | | | |

(17)

1. The first of the two main parts of the report is a description of the work done during the period from 1 January to 31 December 1960.

2. The second part of the report is a summary of the results of the work done during the period from 1 January to 31 December 1960.



3. The third part of the report is a summary of the results of the work done during the period from 1 January to 31 December 1960.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or page 1.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02492

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
THELMA N. KNIGHT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 24, 1981 | | 2b. HOUR
6:17am |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 27, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H.Wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Amos Burriss | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Burriss | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
213-80-0952 | 17. INFORMANT
ADDRESS
Doloras Tolley Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
5609
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) RENAL SHUTDOWN
DUE TO, OR AS A CONSEQUENCE OF
INTESTINAL OBSTRUCTION - BOWEL
3 WKS. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WKS
1 WK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
DIABETES : CHRONIC PYELONEPHRITIS : CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from 1/23 1981 to 1/24 81 , that (b) we last saw the deceased alive on 1/23 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; or (c) we did not view the body after death. | | | | | |
| 22b. SIGNATURE
Donald R. Lewis | | DEGREE
M.D. | | 22c. DATE SIGNED
1/24/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD R. LEWIS MD | | 22e. ADDRESS
OLNEY, Md. 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
Jan. 27, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Colesville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Colesville Mont. Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis H. Barber Laytonsville, Md. 20760 | | 25a. DATE REC'D. BY REGISTRAR
JAN 28 1981 | | | |

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 81 02493 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Evelyn L. Kohler</i> | | | | 2b. HOUR <i>11:20 AM</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>May 6 1896</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., DC</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STREET ADDRESS | | | |
| 13a. STATE <i>-</i> | | 13b. CITY OR TOWN <i>Wash., DC</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS <i>2609-Monroe St., N.E.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John B. McCoy</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma D. Magill</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>577-54-5952</i> | | 17. INFORMANT ADDRESS <i>Mrs. Elaine K. Lilly - 5905-Jamestown Rd., Hyattsville, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Respiratory Failure / Cardiac shock</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>diffuse pulmonary fibrosis</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>prob. due to advanced age -</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>colostomy - Decontamination -</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>NA</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11 19 81</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/17</i> 19 <i>81</i> , to <i>1/27</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/27</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Frederick H. Brennwald MD</i> DEGREE <i>MD</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/28/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F.W. BRENNWALD</i> | | | | 22e. ADDRESS <i>831 University Ave E. Silver Spring MD.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1/10/1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wash., DC Montgomery</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc.</i> ADDRESS <i>4444 Rainier, Md.</i> | | | | 25a. DATE OF DEATH <i>JAN 12 1981</i> REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

BP

1801 S. LRAI

1921/2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 9 4

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Peter KOROBKA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Janaury 2 1981 | | 2b. HOUR
3:34A
M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 4 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55
YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery
MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | 13b. COUNTY
Alexandria | 13c. CITY OR TOWN
Alexandria | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
806 Ramsey Street |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Job Korobka | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
110 18 0785 | | 17. INFORMANT
ADDRESS
Mrs. Delma Korobka See item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: Lung adenocarcinoma
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from Nov. 28 , 19 80 , to January 2 , 19 81 , that (ii) (we) lost above Jan 2 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (iii) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Gary Zaloga, M.D. | | | | 22c. DATE SIGNED
Jan 2, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gary Zaloga, M.D. | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-5-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | | 23e. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | | | |
| 24. FUNERAL DIRECTOR
Everly Wheatley Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1981 | |
| ADDRESS Alexandria, Va. | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 9 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Elizabeth R. Kramer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 11 81 | | 2b. HOUR
2:30a |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
May 30 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Montana | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Librarian-School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Dexter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Bondy | | 13e. STREET ADDRESS
14225 Arctic Avenue | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-40-3421 | | 17. INFORMANT
husband ADDRESS
same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Breast Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11/80
7/80 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/11/81 to 11/11/81 , that (1) was lost
saw the deceased alive on 11/11/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (1) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
PHILIP G. LODMEY | | | | 22c. DATE SIGNED
11/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP G. LODMEY | | | | 22e. ADDRESS
1811 PRINCE PHILIP DR., MD 283 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 14, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Norbeck Memorial Park | |
| 23d. LOCATION
CITY OR TOWN
Olney | | COUNTY
Montgomery | | STATE
Md. | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | |
| 25b. ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | 25c. SIGNATURE
Francis J. Collins | |

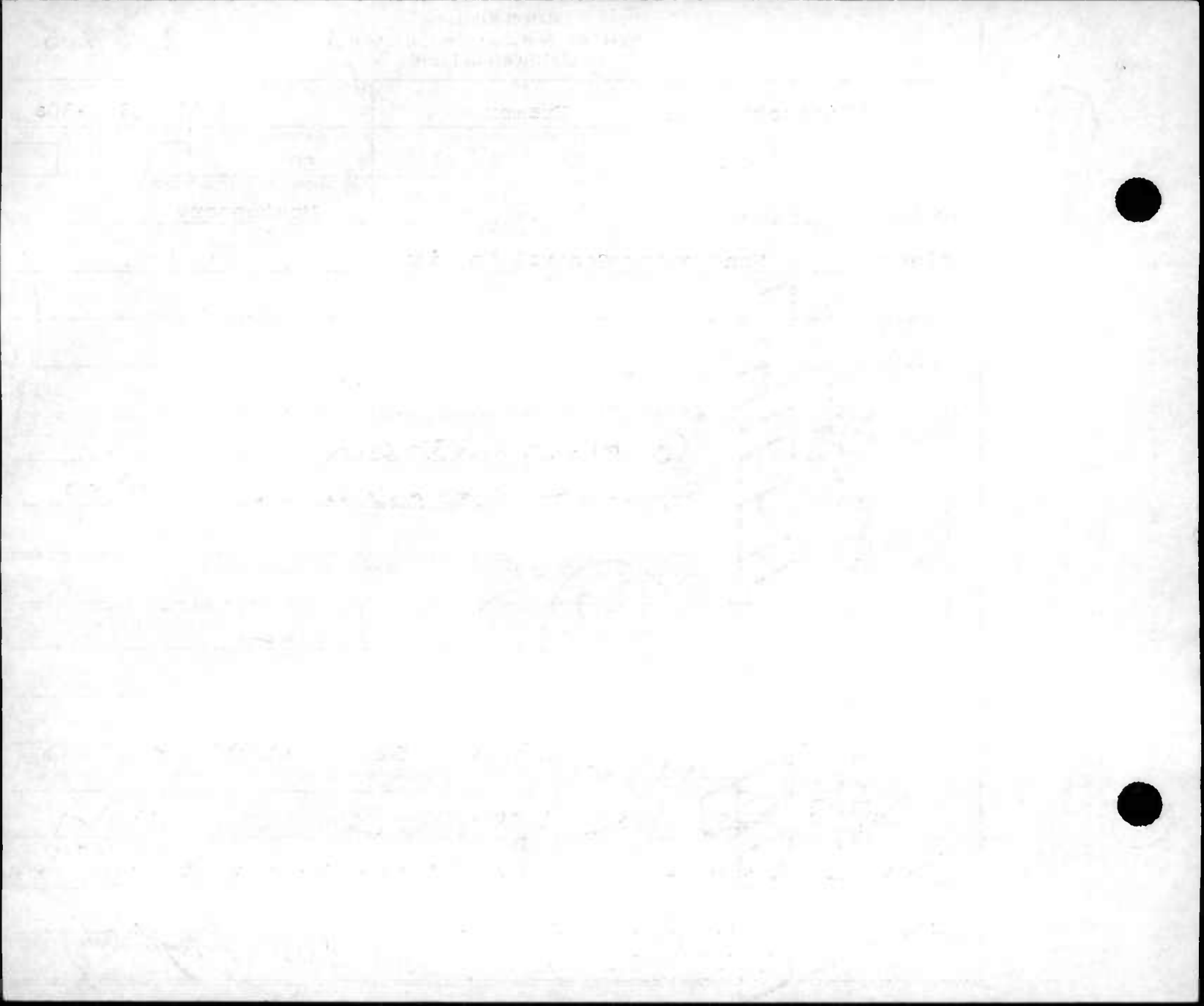
MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 4 9 6 | |
|---|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DAVID - KREIDMAN | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 21 1981 | | 2b. HOUR
2:10 P.M. | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 17 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Romania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Furnier | | 12b. KIND OF BUSINESS OR INDUSTRY
Fur | | | |
| 13a. STATE
MD | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5721 Grosvenor Ln | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACOB M/A Kreidman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adele M/A Bloom | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
068-07-3825 | | | | 17. INFORMANT
Flora Wolf Silver Spg - 20901 | | | | ADDRESS 605 Pentn Pl | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
4380
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) aspirated pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) thromboembolism | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/21/81
1/21/81
yes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to 1/21/81 , 19____, that (I) (we) last saw the deceased alive on 1/21/81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
OSOTH LEKAGUL, M.D. | | | | | | 22e. ADDRESS
7425 arlington rd, Bethesda Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
JAN 23 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring P.G. Md | | | | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers Colma | | | | | | ADDRESS
Silver Spring Md | | 25. REGISTRAR'S SIGNATURE
[Signature] | | | |

STATE OF NEW YORK
IN SENATE
January 11, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE

APRIL 1, 1899

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK
PRINTING OFFICE

1900

1900

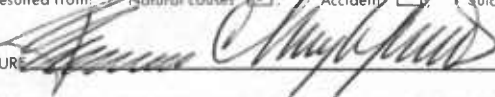
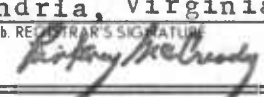
1900

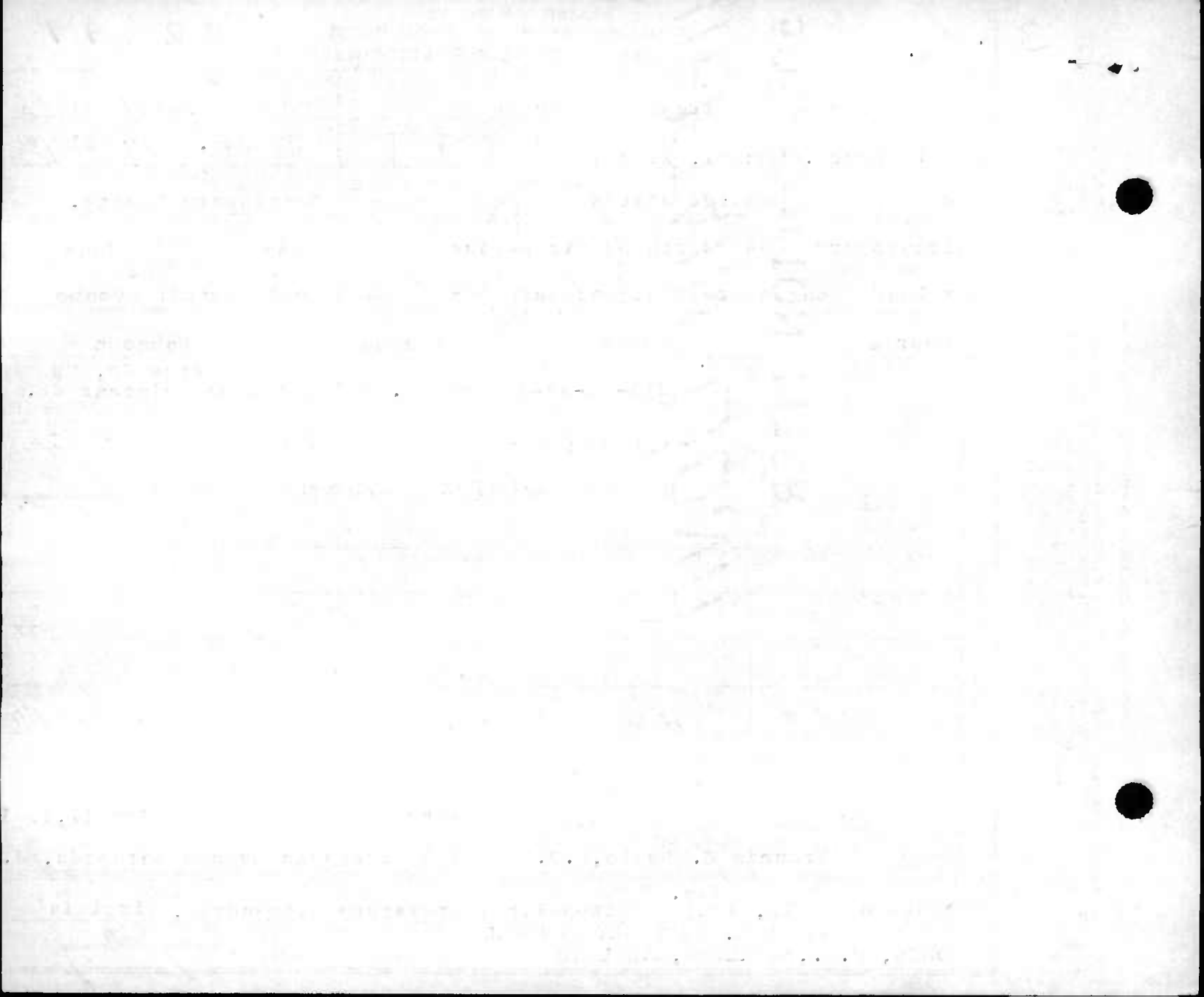
1900

1900

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02497 | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Helen Irene Kuhns | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jan 17 19 81 | | 2b. HOUR 105 AM | | | |
| 3. SEX Female | | 4. RACE Cauca. | | 5. DATE OF BIRTH
MONTH DAY YEAR Aug 7, 1910 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 70 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Jan. 17 19 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
440 North Summit Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | #202 | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
440 North Summit Avenue | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Kuhns | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethelda Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
218-56-9941 | | 17. INFORMANT ADDRESS
Bethesda, MD
Betty E. Walston 7605 Quintana Ct. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4100 MYOCARDIAL INFARCTION
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1 16 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
COLLAPSED ON FLOOR | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
440 N. SUMMIT AVE GAITHERSBURG MONT MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Deputy | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C. Mayle, M.D. | | | | ADDRESS
8200 Wisconsin Avenue Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
Jan. 18, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alexandria, Virginia | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02498

| | | | | | | | | | | | | |
|--|-------------------------|--|--|---|---|--|--|---|---------------------|----------------------------------|---------------------|----------------------------------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
LILLIAN | MIDDLE
P. | LAST
KURLAND | 2a. DATE KNOWN
OF
ESTI-
MATED <input checked="" type="checkbox"/> Jan 3 1981 | | MONTH
Jan | DAY
3 | YEAR
1981 | 2b. HOUR
12:50
a.m. |
| 3. FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH
NOV. DAY
15 YEAR
1917 | 6. AGE (IN YEARS)
LAST BIRTHDAY
63 YRS. | IF UNDER 1 YR.
MONTHS
0 DAYS
0 HOURS
0 MIN | IF UNDER 24 HRS.
HOURS
0 MIN
0 SEC | 7c. DATE
PRONOUNCED
DEAD
Jan 3 1981 | MONTH
Jan | DAY
3 | YEAR
1981 | 2d. HOUR
12:50
a.m. | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS
OR INDUSTRY
OWN HOME | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
*8101 Eastern Avenue | | | | |
| 14. FATHER'S NAME
FIRST
ABRAHAM | | MIDDLE
PAVIS | | LAST
PAVIS | | 15. MOTHER'S MAIDEN NAME
FIRST
ETHEL | | MIDDLE
RAINE | | LAST
RAINE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-18-3973 | | 17. INFORMANT
MILTON C. KURLAND | | ADDRESS
Same as No. 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) Acute Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Viral Infection | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
[Signature] | | TITLE (SPECIFY)
M.D. Dep. | | MEDICAL EXAMINER | | | | DATE
SIGNED Jan 3 1981 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/4/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Memorial Garden | | | | 23d. LOCATION
CITY OR TOWN
Falls Church, Virginia | | | | |
| 24. FUNERAL DIRECTOR
NAME
Donald M. Stein | | HEBREW MEMORIAL F.H.
232 Carroll Street, N. W. Washington, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 4 9 9

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 1 20 81 | | 11 ⁰⁰ A M | |
| Marie C. Kwasegroch | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| female | | white | | MONTH DAY YEAR | | 80 YRS | |
| Jan. 8, 1901 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Illinois | | USA | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Potomac Valley Nursing Home | | housewife | | Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Montgomery | | Potomac | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| James | | McNamara | | no | | 320-10-2905 | |
| 17. INFORMANT | | ADDRESS | | 17a. NAME | | 17b. ADDRESS | |
| John Thomas | | same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) | | 19. IMMEDIATE CAUSE (a) | | 19b. DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1724 | | Inanition | | coma | | 10 da. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | 19c. DUE TO, OR AS A CONSEQUENCE OF | | Metastatic Brain Disease | | | |
| | | 19d. DUE TO, OR AS A CONSEQUENCE OF | | Malignant Melanoma - neck | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| Jan 6 1981 | | Robert T. Thibadeau | | 1-20-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. CITY OR TOWN | | 22g. STATE | |
| Robert T. Thibadeau | | 11125 Rockville Pike | | Rockville, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 1-24-81 | | Assumption Cemetery | | Glenwood, Illinois | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | |
| Tyson Wheeler Funeral Home, Inc. | | 1331 Rockville Pike Rockville, Md. 20852 | | JAN 26 1981 | | J. McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Jan. 8, 1901

to be

to be

Montgomery

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

to be

x

to be

to be

to be

to be

to be

to be

to be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 2 5 0 0 | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Daisy May LaForce | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 25, 1981 | | 2b. HOUR
7:45 P M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 3, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Germantown | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. King | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret N. Bowers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214 09 5206 | | 17. INFORMANT
ADDRESS
William A. LaForce Item 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u>
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/10/75</u> , 19____, to <u>1/25/81</u> , 19____, that (I) (we) last saw the deceased prior on <u>1/16/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Pasqual V. Perrino</u> | | DEGREE
ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | | | 22c. DATE SIGNED
<u>1/26/81</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Pasqual V. Perrino, MD. | | 22e. ADDRESS
15 E. Deer Park Dr., Gaithersburg, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan 29, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Resthaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hagerstown Wash. 1 H. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A. Damascus, Md. | | 24. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey McBrady</u> | | | | | |

MEDICAL CERTIFICATION



Jan. 25, 1961 7:45
Jan 3, 1967
Montgomery
Shady Grove Adventist Hosp. Germantown
17315 Harvestown-Germantown Road
William H. Margaret H. Brown
214 09 5206 William A. Tolson Item 13

xx

Is E. very poor or, disorganized, etc.
Harvestown Wash. D.C.
Jan 22, 1961
William A. Tolson, D.A. Tolson, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 0 1

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANK M. LANHAM | | | 2a. DATE OF DEATH
MONTH JAN. DAY 22 YEAR 1981 | | | 2b. HOUR 2:45 P.M. | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH FEB DAY 27 YEAR 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BICYCLE SHOP OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY
RET. | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONT | | 13c. CITY OR TOWN
TAK. PK. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7051 CARROLL AVE | |
| 14. FATHER'S NAME
FIRST COLUMBUS MIDDLE LAST LANHAM | | | 15. MOTHER'S MAIDEN NAME
FIRST SARAH MIDDLE LAST TALBOT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
577-14-9322 | | 17. INFORMANT
NAME JEAN HOLLIS ADDRESS -1891 PRISCILLA DR S.S. MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4860 Senior respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 Days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Atherosclerotic Cardiovascular Disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 16, 1981 to Jan 22, 1981 , that (I) (we) lost
saw the deceased alive on Jan 20, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) saw the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Benjamin Furman | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-22-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Benjamin Furman | | | 22e. ADDRESS
3720 Vermont Ave. Ken. Md. 20995 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
Jan. 24 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Carmel Cemetery | | 23d. LOCATION
CITY OR TOWN Washington COUNTY D.C. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME THOMAS PAUL HARRIS | | | 25a. DATE REC'D. BY REGISTRAR
JAN 28 1981 | | 25. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a presentation of the results of the study.

4. The fourth part of the report is a discussion of the results and their implications.

5. The fifth part of the report is a conclusion and a list of references.

6. The sixth part of the report is a list of appendices.

7. The seventh part of the report is a list of figures and tables.

8. The eighth part of the report is a list of footnotes.

9. The ninth part of the report is a list of acknowledgments.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 2 5 0 2 | |
|--|--|---|--|--|---|--|---|--|-----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Chat Cong Le | | | | | 2a. DATE OF DEATH
MONTH 1 DAY 16 YEAR 81 | | | | 2b. HOUR
11:15 PM | | |
| 3 SEX
Male | | 4 RACE
oriental | | 5 DATE OF BIRTH
MONTH 4 DAY 3 YEAR 20 | | 6 AGE (IN YEARS LAST BIRTHDAY)
60 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Vietnam | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN USE OF FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Md. State-Human | | 12b. KIND OF BUSINESS OR INDUSTRY
Service Aid | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN S.S. | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
548 Beacon Road | | | | |
| 14 FATHER'S NAME
FIRST Vang MIDDLE Van LAST Le | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Nguyen MIDDLE Thi LAST Xon | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) None | | | 16b. SOCIAL SECURITY NO.
586 50 5717 | | 17 INFORMANT ADDRESS
Thien Thu Le (Son) Same as above | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pancreatic CA = liver metastasis
1579
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c)
DUE TO, OR AS A CONSEQUENCE OF
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 19 80 to 4/16 81 , that (I) (we) last saw the deceased alive on 12/30 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harvey Katzen | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
1-17-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HARVEY KATZEN | | | | | 22e. ADDRESS
6525 Belco Rd. Hottelville, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
1/18/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wash. D.C. | | | | |
| 24 FUNERAL DIRECTOR
NAME Hines/Rinaldi ADDRESS F.H. 11800 N.H. Ave. S.S. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE
Harvey Katzen | | | | |

11:15p 1-1-37 13

Montgomery

Washington, D.C. 20540

1-1-37

Handwritten notes and signatures at the bottom of the page, including "MD" and "K.C.".

1-1-37

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8102503 | |
|---|---|---|--|---|-----------------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Agnes B Ledford</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1-12-81</i> | | 2b. HOUR
<i>9:45 a.m.</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Oct. 9, 1943</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>37</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hosp.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MD.</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Silver Spring</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>James</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Helen Blanche McCann</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>213-42-7267</i> | | 17. INFORMANT
<i>Husband</i> ADDRESS
<i>Jerry R. Ledford same as 13</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Renal Failure</i>
<i>1560</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Gall Bladder Cancer</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 weeks</i>
<i>7 months</i> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<i>Hepatic Failure Intestinal Obstruction</i> | | | | | |
| 19a. DATE OF OPERATION
<i>1/3/81</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Biliary, ureteral, + intestinal obstruction</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>May</i> 19 <i>80</i> , to <i>Jan</i> 19 <i>81</i> , that (1) (we) last saw the deceased alive on <i>1/11/81</i> 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Peter B. Sherer MD</i> | | DEGREE | | 22c. DATE SIGNED
<i>1/12/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>PETER B. SHERER MD</i> | | 22e. ADDRESS
<i>1109 Spring St. #610 Silver Spring, MD 20910</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Jan. 14, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Olivet</i> | |
| 23d. LOCATION CITY OR TOWN
<i>Washington</i> | | COUNTY
<i>D.C.</i> | | STATE
<i>D.C.</i> | |
| 24. FUNERAL DIRECTOR NAME
<i>Francis J. Collins</i> | | 25a. DATE RECEIVED BY REGISTRAR
<i>JAN 16 1981</i> | | | |
| 500 University Blvd. W. Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE
<i>Peter B. Sherer</i> | | | |

BP

DHMH-16 25M
(VRA 15, 4) 1/79

1881 6 17 AL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8102504 | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|----------|---------------------------|--|----------------------------------|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
DORIS M. M. LEFEVRE | | | | | 2a. DATE OF DEATH
1-14-81 | | | 2b. HOUR
7:45 AM | | | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 14 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | | | | | |
| 13a. STATE
Md. | | | | | | | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3716 Manor Road | |
| 14. FATHER'S NAME
Edwin E. Meyers | | | | | 15. MOTHER'S MAIDEN NAME
Edith G. Ashley | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-01-0229D | | 17. INFORMANT
Carolyn Alexander
7815 Aberdeen Road
Bethesda, Md. 20015 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure
4140
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar. 19 71, to Jan. 14, 19 81, that (I) (we) last saw the deceased alive on Jan. 13, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John B. Umhau M.D. | | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
1/14/81 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Umhau M. D. | | | | | 22e. ADDRESS
8805 Conn. Ave. Chevy Chase, Md. 20015 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
1/15/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | 23d. LOCATION
Suitland COUNTY Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons | | | | | 5130 Wisconsin Ave., N.W.
ADDRESS
Wash., D. C. 20016 | | | DATE REC'D. BY REGISTRAR
JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

(5)

John A. Smith

63

X

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

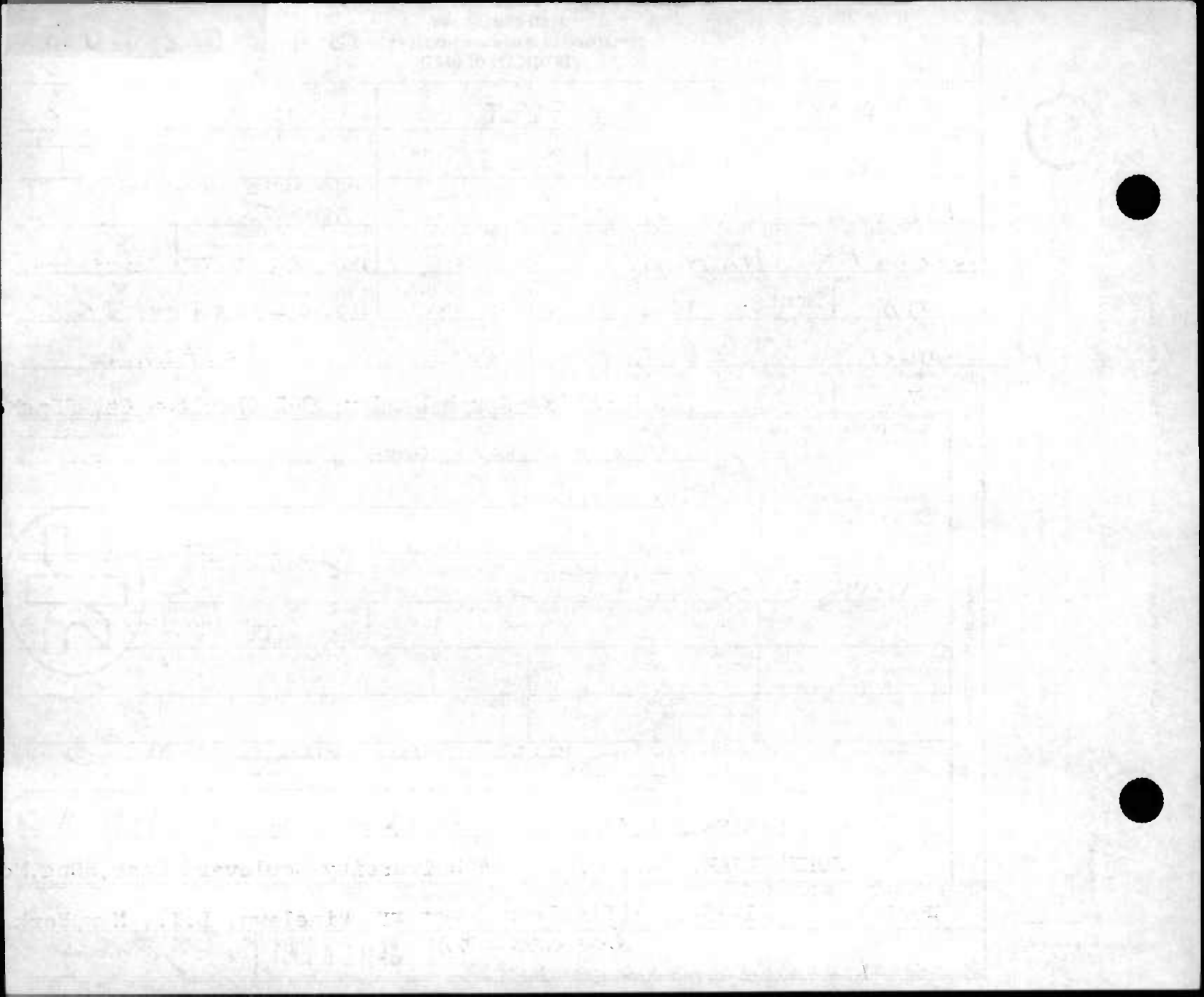
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DAVID LEFFERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-12-81 | | | 2b. HOUR
9:30 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-9-11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONT. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Pk. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
W.A.H. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DENTIST | | 12b. KIND OF BUSINESS OR INDUSTRY
Dentistry | |
| 13a. STATE
MD | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
SILVERSP | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11200 LOCKWOOD DR. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL LEFFERT | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE SALTZMAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ADDRESS
Sarah Landau; 302 Charlton Ct, SSpGMD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute respiratory arrest
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) chronic obstructive pulmonary disease | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Ventricular irritability | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from 12-23 , 19 80 , to 1-12- , 19 81 , that (II) we last saw the deceased alive on 1-12 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John Kijak Jr MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-12-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN KIJAK, JR., M.D. | | | | | | 22e. ADDRESS
344 University Boulevard West, SSpGMD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1-15-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Pinelawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pinelawn, L.I., New York | | |
| 24. FUNERAL DIRECTOR
NAME
DAN ZANSKY 606 BURG 1170 ROCKVILLE MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
Barbara M. ... | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8102506 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | |
| 3 SEX | | | | | | | | | | 7b. HOUR | |
| 4 RACE | | | | | | | | | | 8. AGE (IN YEARS LAST BIRTHDAY) | |
| 5 DATE OF BIRTH | | | | | | | | | | IF UNDER 1 YEAR | |
| MONTH DAY YEAR | | | | | | | | | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 10 CITY OR TOWN OF DEATH | | | | | | | | | | 12b. PUBLIC SCHOOL | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12c. RET. TEACHER | |
| 12. SILVER SPRING CARRIAGE HILL NRSG. CENTER | | | | | | | | | | 12d. PUBLIC SCHOOL | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | |
| 13c. INSIDE CITY LIMITS? | | | | | | | | | | 13d. STREET ADDRESS | |
| 13e. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 9303 HARVEY ROAD, | |
| 14 FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | |
| Levi Mark Hummer | | | | | | | | | | Georgianna Murphy | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | |
| 16c. NO | | | | | | | | | | 216-46-7723 | |
| 17. INFORMANT (son) | | | | | | | | | | ADDRESS | |
| 17a. Henry A. Lepper, Jr. | | | | | | | | | | 10309 RIDGEMOOR DR., S.S. MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | | | | | | | | | | |
| 4360 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Arteriosclerosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19c. DATE OF OPERATION | | | | | | | | | | 19d. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 20c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. TIME OF INJURY | | | | | | | | | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| P.M. 19 | | | | | | | | | | | |
| 21c. INJURY OCCURRED | | | | | | | | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23/81, to present, 1981, that (I) (we) lost the deceased alive on 12/23/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE | |
| 22c. DATE SIGNED | | | | | | | | | | 1/26/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| John B. Umhau MD | | | | | | | | | | 8805 Conn. Ave. Chevy Chase Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | |
| Burial | | | | | | | | | | 1-30-1981 | |
| 23c. NAME OF CEMETERY OR CREMATOR | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Congressional | | | | | | | | | | Washington, D.C. | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR | |
| Warner E. Pumphrey, Inc. | | | | | | | | | | JAN 29 1981 | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | | | | | | |

Georgia W. Lappen

Montgomery County

Silver Spring Carriage Hill Nrs. Center

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02507

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Anna R. Lerch | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/15/81 | | | 2b. HOUR
MIN. 12:45
M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 27 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 yrs. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Reg. Nurse | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11236 Huntover Dr. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew Jacob Leister | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Elizabeth Ashton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
579 60 7214 | | 17. INFORMANT
ADDRESS
Donna Bangor same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pericarditis - cardiac tamponade
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease
(c) Upper respiratory infection | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
15 years
10 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1980 to January 1981 , that (I) (we) last saw the deceased alive on January 14 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. M. Morell | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EVA M. MORELL | | | 22e. ADDRESS
4936 Old Georgetown Rd., Bethesda | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
1/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | | | | | | |

Maryland
 Bethesda
 Montgomery
 Rockville
 X
 1175 Hanover Dr.
 retired
 X
 1175 Hanover Dr.
 Andrew
 Jacob
 Esther
 1175 Hanover Dr.
 no

From the
 1175 Hanover Dr.
 Rockville, Maryland
 1175 Hanover Dr.
 Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 0 8

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
William J. Lester III | | MONTH DAY YEAR
JAN 24 81 | |
| 3. SEX | | 2b. HOUR | |
| Male | | 8 05 P | |
| 4. RACE | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| WHITE | | 60 YRS. | |
| 5. DATE OF BIRTH | | IF UNDER 1 YEAR | |
| MONTH DAY YEAR
6 04 20 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Penn. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | Teacher | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Holy Cross Hospital | | MONT. CTY. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | |
| 13b. STATE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | 13e. STREET ADDRESS | |
| 13c. COUNTY | | 10009 Greeley Ave | |
| 13d. CITY OR TOWN | | 15. MOTHER'S MAIDEN NAME | |
| Silver Spring | | FIRST MIDDLE LAST
REGINA CREEDON | |
| 14. FATHER'S NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| FIRST MIDDLE LAST
WILLIAM J. LESTER, JR. | | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES (W II) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 176-18-0659 | | ADDRESS
MALVINA B. LESTER SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma | | 2 mos | |
| 1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Colon | | 6 mos | |
| (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 80, to 1/24 81, that (I) (we) lost saw the deceased alive on 1/24 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
M. White / RT. Berrack MD | | 22c. DATE SIGNED
1/25/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| M. White / RT. BERRACK MD | | 4115 Colic Drive, Wheaton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| BURIAL | | 1/28/81 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| GATE OF HEAVEN | | CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | |
| FRANCIS J. COLLINS | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | JAN 27 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8102509 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME | | | |
| | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| Ruben - Levin | | | | 1/29/81 | | | |
| 2b. HOUR | | | | 10AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | MONTH DAY YEAR | | 78 YRS. | |
| AUG. 2, 1902 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| POLAND | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Suburban Hospital | | EDITOR | | NEWSPAPER | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | MONT. CO. | | CHESAPEASE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 2712 BLAINE DRIVE | | | |
| BEN - LEVIN | | IDA (UNKNOWN) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | NONE | | 394-10-8160 BERTHA LEVIN (WIFE) | | SAME AS #13. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>renal failure</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>81</u> , to <u>1/29</u> , 19 <u>81</u> , that (I) (we) lost above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Samuel D. Goldberg MD | | | | 1/30/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Samuel D. Goldberg MD | | 11125 Rockville Pike, Rockville, MD 20852 | | BURIAL | | FEB 2, 1981 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| KING DAVID CEMETERY | | FAIRFAX CHURCH, FAIRFAX, VIRGINIA | | FEB 5 1981 | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | 25f. REGISTRAR'S SIGNATURE | |
| CITAMBERS FUNERAL HOME | | SILVER SPRING, MD. | | | | | |

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

VR A15 (4)
FORM REV. 1/68

GENERAL OF DEATH

CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Gertrude Levinson | | | 2a. DATE OF DEATH
MONTH 1 DAY 3 YEAR 81 | | 2b. HOUR
747 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 09 DAY 16 YEAR 03 | 6. AGE (IN YEARS, LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS 77 DAYS 77 | IF UNDER 24 HRS
HOURS 77 MIN. 77 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE
MONTGOMERY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | 12b. KIND OF BUSINESS OR INDUSTRY
Liquor | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD | | 13b. COUNTY MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
8106 NEW HAMPSHIRE AVENUE |
| 14. FATHER'S NAME
FIRST Bernard MIDDLE Ladow LAST Ladow | | 15. MOTHER'S MAIDEN NAME
FIRST Not Ascertainable | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-30-2892 | | 17. INFORMANT
5361 29th Street, N. W.
Washington, D. C. | |

| | | | | | |
|--|--|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA RENAL FAILURE | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
48 HRS | |
| 2506
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | DUE TO, OR AS A CONSEQUENCE OF
(b) POSS. SEPSIS, PULM. EMBOLUS
48 HRS | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF
(c) OLD GANGRENE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ALZHEIMER'S DS, DIABETES, PERIPHERAL VASC DS, ASCAD/CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
747 1 3 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/29/80 to 1/3/81 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on 1/3 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marsha Wallace MD | | | | 22c. DATE SIGNED
1/3/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARSHA T. WALLACE MD | | | | 22e. ADDRESS
916 19th St NW WASH DC 20006 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/4/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Lebanon Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY
Adelphi, Pr. Geo., Maryland | | 23e. REGISTRAR'S SIGNATURE
John J. 1981 | | | |
| 24. FUNERAL DIRECTOR
NAME Donald M. Stein ADDRESS Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C. | | | | | |



[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some words like "HARLEY" and "ROCK" are partially visible.]

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 1 2

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
GWENDOLYN E. LEWIS | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 19, 1981 | | 2b. HOUR
8:56 PM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 25, 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 years YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital E.R. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Libray Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Silver Spring | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
8510 16th #412, | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lloyd R. Lewis, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Geneva Pedea | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-54-7608 | | 17. INFORMANT
ADDRESS
Sister, Sarah McMillin 589-8572 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
<u>1629</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic Oat Cell Carcinoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> , 19 <u>80</u> , to <u>1</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Jay Weimer</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jay Weimer MD | | | | 22e. ADDRESS
50 W. Edmonston Dr Rockville, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1/23/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL HOME
NAME
W. Ernest Jarvis Co., Inc. 1432 U St., NW | | | | DATE REC'D. BY REGISTRAR
JAN 26 1981 | | | |

MEDICAL CERTIFICATION

9
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2602 BP

Jan. 10, 1955

Mr. J. Edgar Hoover

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 1 3

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOURS MIN. | |
| Rita F. Lewis | | 1 9 81 | | 3:00 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | White | MONTH DAY YEAR | 67 YRS. | Montgomery County, MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| New Jersey | U.S.A. | | Assistant | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | |
| Bethesda | Suburban Hospital | Garfinckels | | 4515 Willard Ave. | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | Mont | Chevy Chase | YES <input type="checkbox"/> NO <input type="checkbox"/> | 4515 Willard Ave. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | (YES <input type="checkbox"/> OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| Matthew Feehan | | Grace Downs | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 215-62-6220 | | Gail Lewis Palmer, Dtr., | | Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | 17. INFORMANT | | ADDRESS | |
| IMMEDIATE CAUSE (a) | | Gail Lewis Palmer, Dtr., | | Silver Spring, Md. | |
| 1509 Cardiac respiratory failure | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) pneumonia, congested post-surgery | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) Calcification of esophagus, meta to cardiac node | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-04 19 80 to 1-9 19 81, that (I) (we) last saw the deceased alive on 1-9 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| J.C. DeGuzman MD | | MD | | 1-9-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| J.C. DeGuzman MD | | 1234 19 NW WASH D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/12/1981 | | Ft. Lincoln Cemetery | |
| 24. FUNERAL DIRECTOR | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | |
| Joseph Gawler's Sons, Inc | | Bladensburg, Maryland | | JAN 14 1981 | |
| 5130 Wisc. Ave., Wash., D.C. | | | | | |

Lewis

7.

with

67

1913

15

May

White

Female

U.S.A.

New Jersey

x

Garfield

Assistant

1913 Illinois

Chevy Chase

Front

MA

Home

Place

Lebanon

Match

Silver Spring, Md.

217-42-4220 Bell Lewis Palmer, Dec., 1909 Maryland Dr.

No

Washington, Maryland

U.S. National Cemetery

1/13/1981

Warrior

George Washington's Tomb Inc

2130 Ave. E., Wash., D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|--|---------|---|--|--|-------------------------------|--|--------------------------------|---|-------------------------------------|--------|--|---------------------|
| 1. FOR STATE REGISTRAR | | 2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/22 19 81 | | | | | | | | | | 7a. HOUR P. M. 9:40 |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/22 19 81 | | | | 7a. HOUR P. M. 9:40 |
| William Harrison Lewis | | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1/22 19 81 | | 7b. HOUR P. M. 9:40 | |
| Male | Black | Jun. 28, 1936 | | 44 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Washington, D.C. | | USA | | | | Montgomery County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | | 10131 Greenock Road | | | | Military Retired | | US Army | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Maryland | | Montgomery | | Silver Spring | | | | 10131 Greenock Road | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| Unknown | | | | Elsie Clark | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | |
| Yes | | Vietnam | | 579-46-4401 | | Mitsuko Lewis 10131 Greenock Rd. Sil. Spg. Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| None | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| None | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | | | None | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE | |
| | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John S. Rogers</u> | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 1/23/81 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | | | |
| Burial | | Jan. 30, 1981 | | Arlington National | | Fort Myer | | Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McGuire Funeral Service 7400 Ga. Ave. N.W. DC | | | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1981 | | 25b. REGISTRAR'S SIGNATURE <u>John S. Rogers</u> | | | | | | |

•

BH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

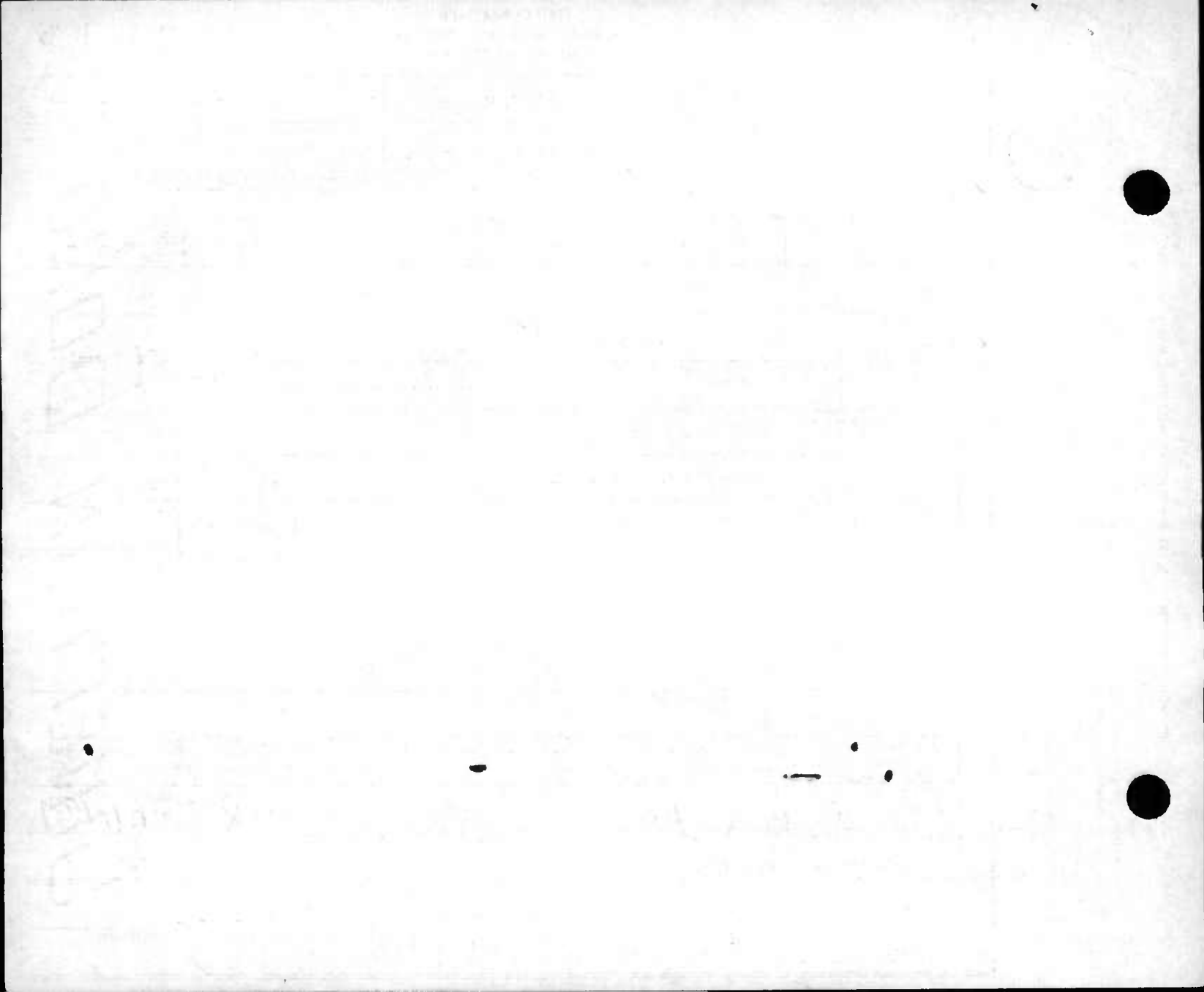
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 1 5

REG. NO.

| | | | | | | |
|---|--|--|---|---|---------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RONALD ALLEN LINICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 31, 1981 | | 2b. HOUR
1:25 ^P M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 1, 1941 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS. | | 7. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE CLINICAL CENTER | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY
US Gov't | | 13a. STREET ADDRESS
1121 HIATUS ROAD (33026) | | |
| 13a. STATE
FLORIDA | | 13b. COUNTY
Broward | | 13c. CITY OR TOWN
PEMBROKE PINES | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sidney C. Linick | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Yetta (NMN) Dobrovsky | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | |
| 16b. SOCIAL SECURITY NO.
338-34-4765 | | 17. INFORMANT
MRS. JUDY LINICK (NOK) | | 18. SAME AS ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Mixed Cerebral Guoma
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1919 | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (this hospital) attended the deceased from DECEMBER 30, 19 80, to January 31, 1981, that (we) last saw the deceased alive on JANUARY 31, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated. | | 22b. SIGNATURE
Edward G. Ginnis MD | | |
| 22c. DATE SIGNED
Feb 1, 1981 | | 22d. ADDRESS
NATIONAL INSTITUTES OF HEALTH
THE CLINICAL CENTER, BETHESDA, MARYLAND | | 22e. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2Feb 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02516 | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) RUTH E. M. LONG | | | | | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR 1 11 81 | | 2b. HOUR 8:30 AM | |
| 1. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 12 1 92 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 88 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1 11 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mich. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY
Treasury | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN GLEN ECHO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6001 BRYN MAWR AVE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Floyd T. Moore | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ann Liddy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-22-7912 | | 17. INFORMANT ADDRESS
Nancy Long Same as Item # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Fracture Rt Hip | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 1 11 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FELL AT HOME | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6001 Bryn Mawr Ave Glen Echo Mont Md | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE Francis C Mayo | | | | TITLE (SPECIFY) Dpt | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayo | | | | ADDRESS 8200 Wisconsin Ave Bethesda Md | | | | DATE SIGNED 1/11/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/13/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Md. | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
Patricia Hebrady | | | |
| NAME ADDRESS
5130 Wisc. Ave. N.W. Wash., D.C. | | | | | | | | | | | |

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

5800

• 2015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02517

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM E LUSKEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 18 81 | | | 2b. HOUR
MIN.
4:50 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-22-1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
77 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Steamfitter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Hy. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5715 - Jamestown Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elvin M. Luskey | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice M. Lanham | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
ADDRESS
Alice R. Luskey (Wife) | | Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
1519
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) hypertension | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 8/1 19 81 , to 1/18 19 81 , that (he/she) last saw the deceased alive on 1/18 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we did not view the body after death). | | | | | | 22b. SIGNATURE
[Signature] | | 22c. DATE SIGNED
1/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1-21-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Geo. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 1 8

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST SALVATORE MIDDLE Magri LAST Magri | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/29/81 | | 2b. HOUR
2:50 P.M. | |
| 3. SEX
male | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN 27, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | 7b. CITIZEN OF WHAT COUNTRY?
ITALY | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CABINET MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
WHEATON | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
10908 GLENHAVEN PARK |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANTONIO MAGRI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CARMELA MAGRI | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO.
216-58-6751 | | 17. INFORMANT
ANTHONY MAGRI | | ADDRESS
SAME AS 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute cardiac failure
DUE TO, OR AS A CONSEQUENCE OF
(c) hypertension | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/24 , 19 81 , to 1/29 , 19 81 , that (I) (we) last saw the deceased alive on 1/29 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
E. H. Levin | | DEGREE
M.D. | | 22c. DATE SIGNED
1/29/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDGAR H. LEVIN | | 22e. ADDRESS
8630 FERTON ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

U.S. 100

100

FEB 3 1981

100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 1 9

1- FOR
STATE
REGISTRAR

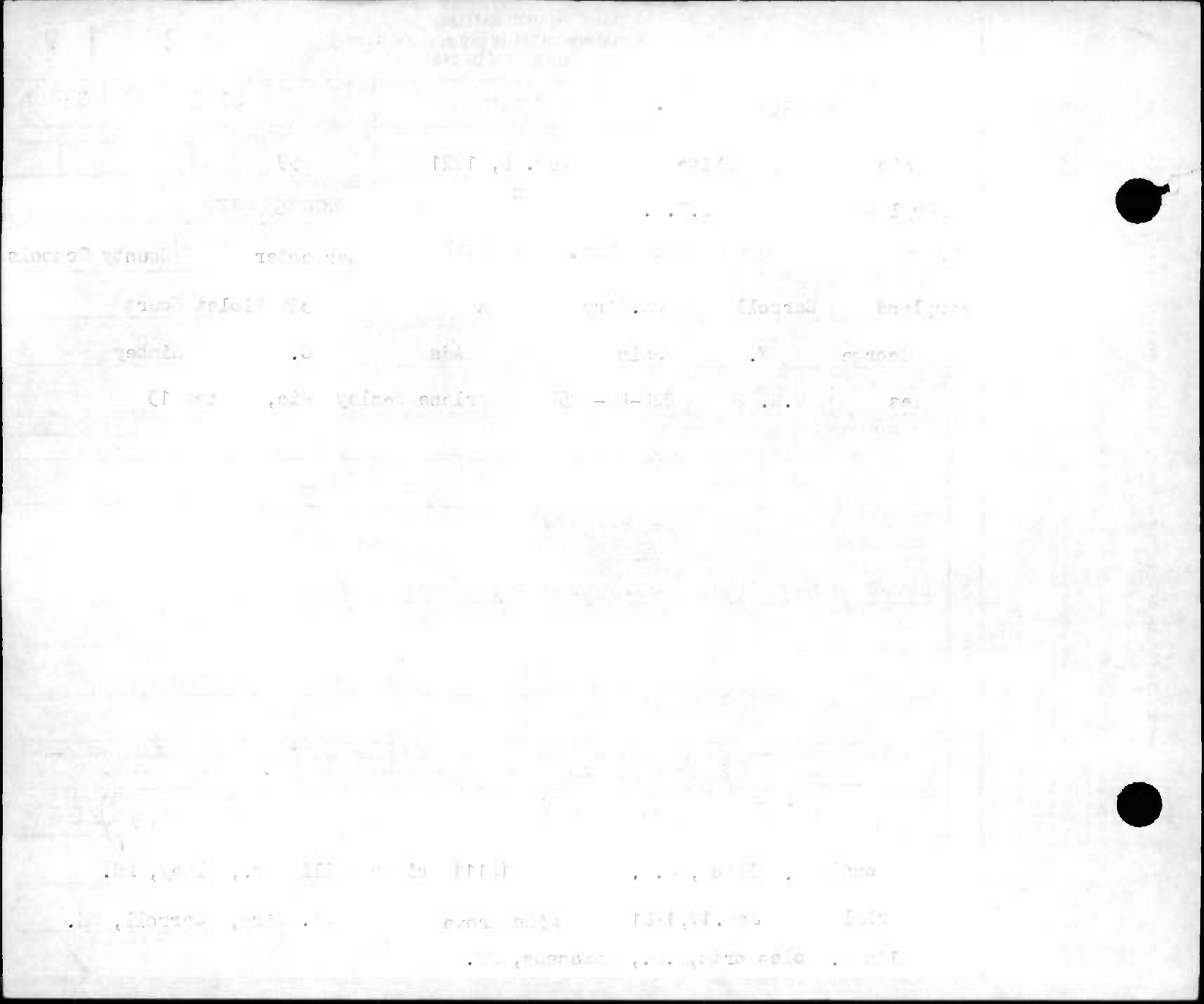
REG. NO.

| | | | | | | | | |
|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George N. Main | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 14 81 | | | 2b. HOUR
3:45A
M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 8, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
County Schools | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Carroll | | 13c. CITY OR TOWN
Mt. Airy | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George E. Main | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada C. Rimbey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W. 2 220-09-0050 | | 17. INFORMANT
ADDRESS
Arlene Bosley Main, Item 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Septic Shock and acute renal failure</u>
<u>1850</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>failure</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of prostate</u>
Severed years. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 d. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Lymph node, diffuse bone, possibly liver metastases.</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>13 Jan 81</u> to <u>14 Jan 81</u> , that (I) me saw the deceased alive on <u>13 Jan 81</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Donald E. Dillon M.D.</u> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
<u>14 Jan 81</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | | | 22e. ADDRESS
18111 Prince Philip Dr., Olney, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 17, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mt. Airy, Carroll, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., Damascus, Md. | | | | 25a. RECEIVED BY REGISTRAR
JAN 19 1981 | | 25b. REGISTRAR'S SIGNATURE | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 **2 5 2 0**
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Charles Westcott Mallard | | | 2a. DATE OF DEATH
Month January Day 20 Year 1981 | | | 2b. HOUR 9:30 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Feb. 14, 1919 | | 6. AGE (In years lost birthday)
61 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
9212 Weathervane Place | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Claude Middle - Last Mallard | | 15. MOTHER'S MAIDEN NAME
First Esther Middle - Last Westcott | | 13e. STREET AND NUMBER
9212 Weathervane Place | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) Yes (If yes give war or dates of service) Korea | | 16b. SOCIAL SECURITY NO.
715-01-0815 | | 17. INFORMANT
Steve Mallard Fairfax, Va. 22031 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia
2050 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Polyarteritis Vera
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months
7 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertension. Stroke in association with RX of Leukemia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May , 19 74 , to Jan 30 , 19 81 , that (I) (we) last saw the deceased alive on Jan 19 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Eugene P. Libore MD DEGREE MD | | | | 22c. DATE SIGNED
20 Jan 1981 | | | |
| 22d. PHYSICIAN'S NAME (Type)
EUGENE P. LIBORE | | | | 22e. ADDRESS
10406 COMB AVE
KELWINGTON, MD. 20785 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 23, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | 23d. LOCATION (City or Town) (County) (State)
Arlington Arlington Va. | |
| 24. FUNERAL DIRECTOR
Rosabeth Sandison | | ADDRESS
316 E. Diamond Ave. | | 25a. REC'D BY REGISTRAR
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE
Mary McQuerry | |
| Gartner Sandison F. H. | | Gaithersburg, Md. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN, The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on death, when any injury or other traumatic event, the medical examiner must be notified at once.

C. Mayle Medical Examiner notified and released

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 2 1 | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HERMILINE T. MAROTTE | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 2, 1981 | | 2b. HOUR
3:35PM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 19, 1888 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
92 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. STATE
Massachusetts | | 13b. CITY OR TOWN
Bristol | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
25 Warren Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David Therriault | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HERMILINE BREARD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
036 42 1648 | | 17. INFORMANT
Nedra Rowe Daughter 4613 N. Chelsea Lane Bethesda, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
7854
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Systolic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Compromise of the foot (e)</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2 Jan</u> , 19 <u>81</u> , to <u>2 Jan</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2 Jan</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
S. Anderson | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
Jan. 2, 1981 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EMMA C. ANDRES M.D. | | 22e. ADDRESS
8600 Old Georgetown Rd., Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial-Removal | 23b. DATE
Jan. 4, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph's | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Taunton, Massachusetts | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR
JAN 1 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

15050

8 1 0 2 5 2 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|-----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | MIDDLE | | LAST | | 6. DATE OF DEATH | | MONTH DAY YEAR | | 7b. HOUR | |
| LORAINÉ | | B. | | MARTENS | | JANUARY 11, 1981 | | | | 4:40A.M. | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | White | | Nov. 30, 1896 | | 84 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Wisconsin | | US | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| ROCKVILLE | | ROCKVILLE NURSING HOME | | | | Homemaker | | Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md. | | Montgomery | | Kenwood | | | | 6408 Highland Dr. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| Peter H. Brodesser | | | | Ottilia Kessler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 392-46-8050 | | Harry Martens Same as Item # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c) Sepsis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Senility - | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 31, 1979, to Jan 4, 1981, that we (we) lost
saw the deceased alive on Feb 1, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (True) (False) (did not view the body after death) | | | | | | | | | | | |
| 22b. SIGNATURE
Horace W. Bernston | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HORACE W. BERNSTON M.D. | | | | | | 22e. ADDRESS
4743 Bradley Blvd., Chevy Chase, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1/15/81 | | Holy Cross Cem. | | Wauwatosa Milwaukee, Wisc. | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 Wisc. Ave. N.W. Wash., D.C. 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 2 3

REG. NO.

| | | | | | | |
|--|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EMMA B. MARTIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 25, 1981 | | 2b. HOUR
3:45am | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC 24, 1895 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MINNESOTA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
85 | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ADM. ASSISTANT | | 12b. KIND OF BUSINESS OR INDUSTRY
I.R.S. | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3510 FOREST EDGE DRIVE | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEO BIEBL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
THERESA BAYER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-62-0108 | | 17. INFORMANT
ADDRESS
FRED S. MARTIN SAME AS 13 HUSBAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4465 Huge Pulmonary embolus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Leg phlebotomies
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) Heart Cell arteritis year | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Senile Dementia | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1979 to 24 January 1981 , that (I) was last saw the deceased alive on 24 January 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Gustavo S. Belavai, MD | | DEGREE
MD | | 22c. DATE SIGNED
1/23/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GUSTAVO S. BELAVAI | | 22e. ADDRESS
Leisure World Medical Center Silver Spring, Md 20906 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1-29-81 | | 23c. NAME OF CEMETERY OR CREMATORY
RIVERSIDE CEMETERY | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BARNUM CARLTON MINN | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE
History/Registry | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 2 4

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|------------------------|---|--|--|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MAY MASON | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 26, 1981 | | 2b. HOUR
11:30 A.M. | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 19 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13705-Carlisle Ct. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Passport Exam. | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil.Spg. | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13. STREET ADDRESS
13705-Carlisle Court | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry M. Yinger | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Negley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-60-0593 | | 17. INFORMANT ADDRESS
Shirley Stuntz Same as 13 E. | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RECURRENT CARCINOMA @ RECTAL LOWLY LIP
1701
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) CARCINOMA @ HAND/BLADE

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 1/2 years

1978

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
10/18, 11/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CARCINOMA OF HAND/BLADE, RIGHT | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> 19 <u>78</u> , to <u>DEC. 31</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>DEC. 31</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>I. Sidney Jaffee</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/2/81 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
I. Sidney Jaffee MD. | | | | 22f. ADDRESS
8830-Cameron St. Silver Spring, Md. | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. | | 23d. LOCATION
CITY OR TOWN COUNTY
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. Inc. | | | | ADDRESS
11800-N H Ave
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Hines/Rinaldi</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by voice.

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

1 3 5 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8102525 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ronald Richard MASON | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 16 1981 | | 2b. HOUR
10:45A | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 26 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Virginia | | | | | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Annandale | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard Eugene Mason | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4720 Playfield Street 22003 | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
E. Katrina Hilliard | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes 1960-1980 | | | | | |
| 16b. SOCIAL SECURITY NO.
134 28 1254 | | | | | | 17. INFORMANT
ADDRESS
Wife, Kathleen Mason, see line 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
1529
DUE TO, OR AS A CONSEQUENCE OF
(b) Adenocarcinoma, small bowel, metastatic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 1 , 19 80 , to Jan. 16 , 19 81 , that (I) (we) last saw the deceased alive on Jan. 16 , 19 81 , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Glenn M. Davis</i> M.D. DEGREE | | | | | | | | 22c. DATE SIGNED
Jan. 16, 1981 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Glenn M. Davis, M.D. | | | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | | | 23b. DATE
1/21/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Demaine Funeral Home, Alexandria, Va 22314 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

RECEIVED FROM THE

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 2 5 2 6

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|-------------------------|---|--|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
David XXXXX Mastbrook | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
1/4 1981 | | | 2b. HOUR
12:30 P. M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sep. 20, 1897 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
83 | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.
XX | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1/4 19 81 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3398 Gleneagles Drive, #2D | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS
Golf Shop | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
3398 Gleneagles Drive, #2D | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William -- Mastbrook | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen -- Leighkite | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
----- 577-09-7396 | | | | 17. INFORMANT (wife) ADDRESS
Helen I. Mastbrook-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
4291
(b) chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, M.D. | | | | ADDRESS | | | | DATE SIGNED
1/5/81 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1-6-1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Georges Md. | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | ADDRESS
8434 Ga. Ave., S.S. Md. | | | | 25a. DATE
JAN 8 1981 | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

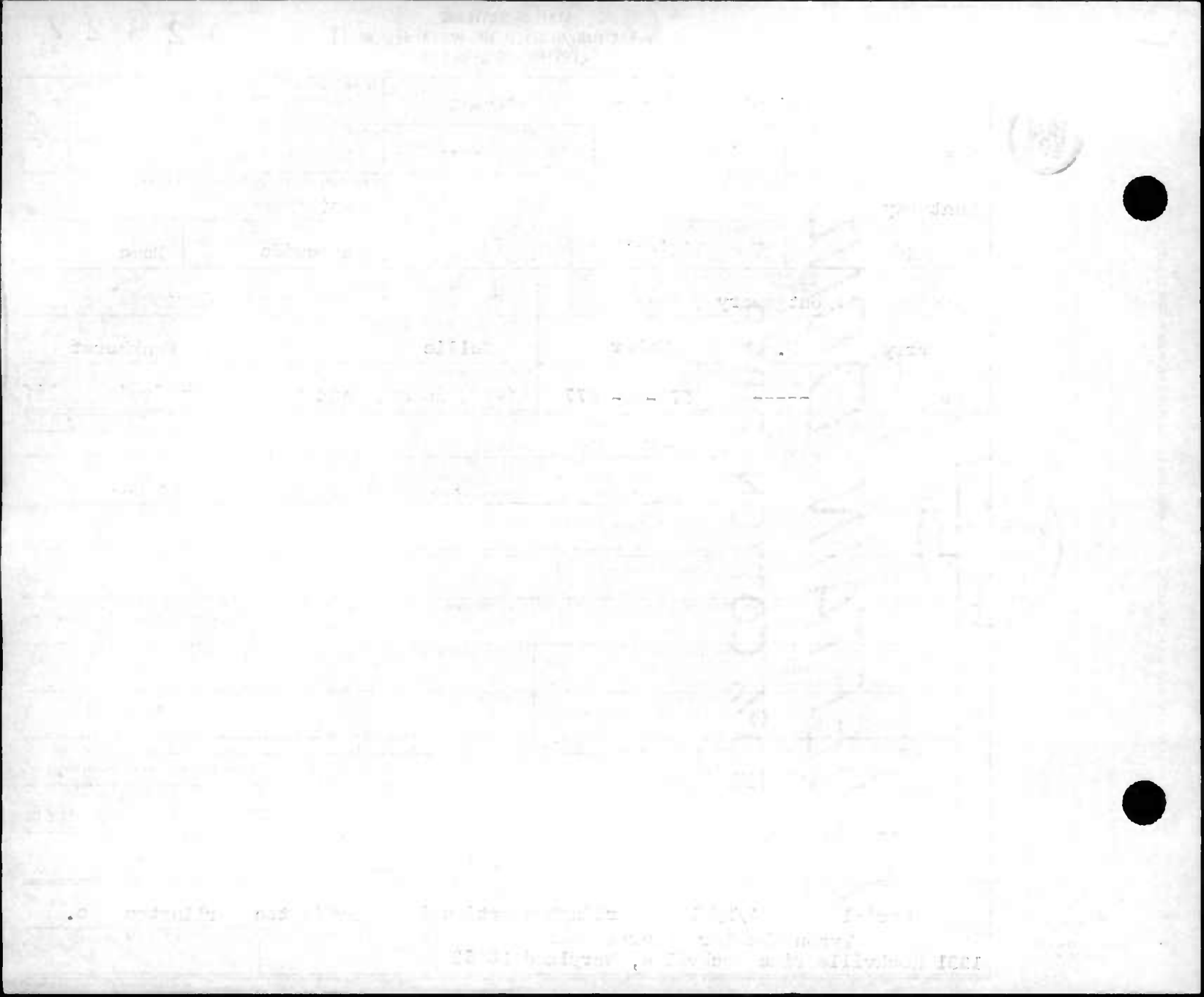


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|---|--------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marjorie Louise Matthews | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 28, 1981 | | 2b. HOUR P M
9:00 P M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 24, 1917 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
63 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 8. CITIZEN OF WHAT COUNTRY?
USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Clinical Center, NIH | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | 13a. STREET ADDRESS
4512 Dresden Street | | |
| 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry F. Weber | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie Dunkhorst | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
578-40-0077 | | 17. INFORMANT
Lieut. Robert Matthews, son, Ft. Irwin, Calif. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Tamponade (Post Mortum)</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic adenocarcinoma of breast</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>22 January</u> , 19 <u>81</u> , to <u>28 January</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>28 January</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
<u>Srinivasan - B.</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/29/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SRINIVASAN - B. | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | | 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home
1331 Rockville Pike Rockville, Maryland 20852 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 5 2 8 | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST
Anthony Mazzei | | | | MONTH DAY YEAR
1 / 28 / 81 | | | | 12 15 P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| male | | White | | MONTH DAY YEAR
10 8 1897 | | 83 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| New York | | U. S. A. | | | | Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | | | Furniture Mfg | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | | Prince Geo | | Bowie | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3909 Carvel Lane | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
Nichols Mazzei | | | | FIRST MIDDLE LAST
Concetta Unk | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | 025-05-8124 | | John McManus F. H. Ave., Brooklyn, N.Y. | | 2001 Flatbush | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>gram negative sepsis</u>
<u>4409</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>urinary tract infection</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic vascular disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) <u>(did not)</u> attended the deceased from <u>JAN 28</u> , 19 <u>81</u> , to <u>28 JAN</u> , 19 <u>81</u> , that (I) <u>(did not)</u> saw the deceased alive on <u>JAN 28</u> , 19 <u>81</u> , and that in (my) <u>(best)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did not)</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter E. Goetz</u> | | | | | | | | | | 22c. DATE SIGNED
28 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOZET MD | | | | | | | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1/31/81 | | Evergreen Cemetery | | Brooklyn, N.Y. | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Ga. Ave. Sil. Spr., Md.</u> | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after date with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | 7a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | JAN. 23 81 | | 955 P.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | MONTH DAY YEAR | | 48 YRS. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| WHEATON | | 2804 PARKER AVENUE | | SECRETARY | | NAVY DEPT. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | NO | | 218-30-4538 | |
| ROSS | | FARRAR | | 17. INFORMANT | | ADDRESS | |
| | | | | SISTER | | 2804 PARKER AVENUE | |
| | | | | BETTY SONNENBERG | | WHEATON, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991 METASTATIC ADENOCARCINOMA | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MO |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 1-23 81, that (I) (we) last saw the deceased alive on 1-8 81, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| George Sengstack M.D. | | | | 1-23-81 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. ADDRESS | | | | | |
| GEORGE SENGSTACK | | SILVER SPRING MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 1/27/81 | | GRAVEL SPRINGS CEMETERY | | STAR TANNERY FRED. VA. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | JAN 27 1981 | | Randy R. Brady | | | |
| 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901 | | | | | | | |



Jan 20 1951

Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

1951

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WALTER J. McCOMB | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN. 19 1981 | | 2b. HOUR
1:30 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 24, 1885 | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
? | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SLIGO GARDENS NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ph D. Columbia Union | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Takoma Park | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
McCOMB | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NOT AVAILABLE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
220-34-4967 | | 17. INFORMANT
Silver Spring, Md. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4275
IMMEDIATE CAUSE (a) 1) Respiratory and Cardiac Arrest.
DUE TO, OR AS A CONSEQUENCE OF
(b) 2) Senile Dementia.
DUE TO, OR AS A CONSEQUENCE OF
(c) 3) Anemia. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JUNE 78 , 19____, to 1/19 , 19 81 , that (I) (we) last saw the deceased alive on Jan 10 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Smith Ho | | DEGREE | | 22c. DATE SIGNED
1/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SMITH S. HO, M.D. | | 22e. ADDRESS
8323 Haddon DR Takoma PK md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
Jan. 22, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bladensburg Rd. P. Geo. | | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Park Hygiene Service | | DATE FILED BY REGISTRAR
JAN 22 1981 | | | |

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

| | | | | | |
|---|---------|--|-------------------|--|---------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Robert Alexander McConnell | | 1/31 1981 | | 10:20 A. M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Male | White | Feb. 6, 1908 | 72 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Pennsylvania | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) | |
| Silver Spring | | 614 Sligo Avenue, #104 | | Retired | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Montgomery | | Silver Spring | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| Alexander McConnell | | Mary Jane Orr | | 16b. SOCIAL SECURITY NO. | |
| | | | | 166-09-5515 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 619 Hartman Avenue, Penna. 19560 | | PART I DEATH WAS CAUSED BY: | | | |
| | | IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> | | | |
| | | (b) <u>chronic myocardial disease.</u> | | Years | |
| | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | None | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | None | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>John S. Rogers</u> | | M.D. Deputy | | 1/31/81 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| John S. Rogers, M.D. | | 1919 Seminary Road Silver Spring, Montgomery, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | | | Hillside Cemetery | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Philadelphia | | FEB 9 1981 | | | |
| 23g. NAME OF CEMETERY OR CREMATORY | | 23h. COUNTY | | 23i. STATE | |
| Hillside Cemetery | | Philadelphia | | Penna. | |
| 23j. NAME OF CEMETERY OR CREMATORY | | 23k. COUNTY | | 23l. STATE | |
| Hillside Cemetery | | Philadelphia | | Penna. | |
| 23m. NAME OF CEMETERY OR CREMATORY | | 23n. COUNTY | | 23o. STATE | |
| Hillside Cemetery | | Philadelphia | | Penna. | |

WALTER E. PUMPHREY, INC.,

8434 Ga. Ave., S.S. Md.

DATE REC'D. BY REGISTRAR

FEB 9 1981

REGISTRAR'S SIGNATURE

John S. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE WITH THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR 115 ME (5))
15M 7/76

104
105



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 3 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eleanor M. McCormick | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01-05-81 | | | 2b. HOUR
12:55 P | | | |
| 3. SEX
F | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-29-04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Resident Dir. Dormitory | | 12b. KIND OF BUSINESS OR INDUSTRY
Ret. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
MD. Pr. Geo. Hyattsville | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
6500-Riggs Rd. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Patrick J. Dougher | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Mary Fuery | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
John R. McCormick - (Son) | | ADDRESS
113B Fairway Dr. Wethersfield, Conn. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute bronchitis
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF
(c) By | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 wk | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:30 P.M. 1/8/81 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8/81 to 1/8/81 , that (I) (we) lost
saw the deceased alive on 1/8/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin | | | | | | DEGREE
MD | | 22c. DATE SIGNED
1/8/81 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN | | | | | | 22c. ADDRESS
2309 SHOREFIELD RD
WHEATON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
1/8/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cre. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Valley's F.H. Inc. | | | | | | ADDRESS
Mt. Rainier, Md. | | 25. DATE REC'D. BY REGISTRAR
JAN 12 1981 | |

MEDICAL CERTIFICATION

9
9
1

BP

OHHM-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LET'S TALK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 2 | 5 | 3 | 3 |
|---|--|---|--|---|--|--|--|--|--|---|---|-----------------------------|---|-----------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM J Mc DONALD, Jr. | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 20 1981 | | | | 2b. HOUR 2:00 PM | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 27 1923 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. Separated
MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY I.R.S. | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STREET ADDRESS | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Maryland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 17612 Kohlhoss Road, | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William John McDonald | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothea Slipper | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | | | |
| 16b. SOCIAL SECURITY NO. WW 11 215-14-4790 | | | | | 17. INFORMANT John McDonald-son-Haymarket, Va. 22069 | | | | | ADDRESS 15756 Wakefield Ct. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1729 RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL OBSTRUCTED URETERS
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED METASTATIC MELANOMA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 WEEKS
1 MONTH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
HYPERTENSIVE VASCULAR DISEASE - GOUT | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lawrence D. Marcus DEGREE MD | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/20/81 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE D. MARCUS, MD. | | | | | | | | 22e. ADDRESS 1111 SPRING ST., SILVER SPRING, MD. 20910 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-26-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Cemetery | | | | 23d. LOCATION UPPER TOWN COUNTY STATE | | | | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS 8434 Ga. Ave., S.S. Md. | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony McCready | | | | | | |

(M)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME(5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|------------------|--|-------------|---|-------------------------|--|---|--------------------------|-------|----------|-------|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Francis | MIDDLE
L | LAST
McDuffie | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | MONTH | DAY | YEAR | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR |
| Male | | Cauca. | June 9, 1907 | 73 | YRS. | | | | | Jan. 31, 1981 | | | 12 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| North Carolina | | United States | | | | Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | Suburban Hospital | | Salesman | | Automobile | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4615 Sleaford Road | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Dan | | Bessie | | NO | | 577-10-8448 | | Kathleen L. McDuffie | | Same as item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 5712 | | | | Renal Failure - Acute | | | | | | | | | |
| | | | | (b) Cirrhosis of Liver & Ascites | | | | | | | | | |
| | | | | (c) Chronic ingestion of Alcohol | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | Cardio-Vascular Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. EXTERNAL CAUSE WAS WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | M.D. | | MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | John G. Ball, M.D. | | ADDRESS | | 7936 Old Georgetown Rd. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| Cremation | | February 1, 1981 | | Metropolitan Crematory, Alexandria, Virginia | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ROBERT A. BUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| | | | | FEB 5 1981 | | [Signature] | | | | | | | |

BP

1992

• • • • •

TABLE 1. *Continued*

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 5 3 5

FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Martha A. McGinn | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 3, 1981 | | 2b. HOUR
6:34pm |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Apr. 4 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Iowa | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
15301 Pine Orchard Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael McGinn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Fagan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
340-10-3349 | | 17. INFORMANT
ADDRESS
Gertrude M. Maloney Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital) attended the deceased from 1/3 19 81 to 1/3 19 81 , that (b) (we) lost
saw the deceased alive on 1/3 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (b) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. R. O. S. 2011 N | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. R. O. S. 2011 N | | 22e. ADDRESS
3701, Rossman Blvd. Md. Silver Spring | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 6, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | ADDRESS
500 University Blvd., W. Silver Spring, Md. | | DATE REC'D. BY REGISTRAR JAN 5 1981
REGISTRAR'S SIGNATURE
Robert M. Brady | |

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

THE UNIVERSITY OF CHICAGO
LIBRARY

White
Apr. 1, 1888
Manager

Executive Secretary

1888 The Standard

Montgomery Silver Spring

Chicago

From
The Standard

Chicago

White

Chicago

510-10-1000 Chicago, Ill. White Silver Spring, Ill.

10

THE UNIVERSITY OF CHICAGO
LIBRARY
500 University Club, Silver Spring, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 1 0 2 5 3 6 | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
OWEN BERNARD McGLYNN, SR. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 15, 1981 | | | 2b. HOUR
7:45P M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
AUG 5, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RANDOLPH HILLS NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SECURITY GUARD | | 12b. KIND OF BUSINESS OR INDUSTRY
N.O.L. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4601 CREEK SHORE DRIVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
OWEN McGLYNN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELIZABETH McDERMOTT | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | (IF YES, GIVE WAR OR DATES)
WW II | | 16b. SOCIAL SECURITY NO.
187-03-3597 | | 17. INFORMANT ADDRESS
OWEN B. McGLYNN, JR. SAME AS 13 SON | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive left cerebral infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
<u>4349</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>year</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>FEB 7</u> 19 <u>81</u> to <u>1/15</u> 19 <u>81</u> , that (2) we last saw the deceased alive on <u>1/13</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (and not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Martin C. Shargel</u> | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 16, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL, M.D. | | | 22e. ADDRESS
3720 FARRAGUT AVE
KENSINGTON MD-20795 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1/19/81 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MARY'S IMMACULATE CONCEPTION CHURCH CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
WILKES BARRE LUZERNE PA | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | | 25b. REGISTRAR'S SIGNATURE
<u>John H. Brady</u> | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. | | | | | | | | | |

THE S. I. HALL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 3 7
REG. NO. | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Thomas C. McGreen | | | | 2a DATE OF DEATH
MONTH DAY YEAR
01 12 81 | | | | 2b HOUR
12 21 M | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
11 28 21 | | 6 AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | 7a IF UNDER 1 YEAR
MONTHS DAYS | | 7b IF UNDER 74 HRS
HOURS MIN. | |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RHODE ISLAND | | 7d CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ENGINEER NAVAL | | 12b KIND OF BUSINESS OR INDUSTRY
SURFACE WEAPONS | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b STATE
Maryland | | | | 13c COUNTY
Mont. | | 13d CITY OR TOWN
Silver Spring | | 13e INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f STREET ADDRESS
109 Whitmoor Terr. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
THOMAS E. MCGREEN | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELEN CONNERY | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b SOCIAL SECURITY NO
036-14-3205 | | 17 INFORMANT
CLARA M. MCGREEN | | ADDRESS
SAME AS 13 | | WIFE | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute congestive failure
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) stenocardiac heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes mellitus | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
hours
years
years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
squamous cell carcinoma | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (this hospital) attended the deceased from 12/31 19 80, to 1/12 19 81, that (we) lost
saw the deceased alive on 1/12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (If we did not view the body after death) | | | | | | | | | | | |
| 22b SIGNATURE
Nelson F. Koch | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
1/12/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Nelson F. Koch | | | | 22e ADDRESS
201 MEDICAL CENTER RD,
SILVER SPRING, MD 20902 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b DATE
1/15/81 | | 23c NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT. MD. | | | | | |
| 24 FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a DATE REC'D BY REGISTRAR
JAN 16 1981 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 5 3 8

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Gladys P. McKay | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 20, 1981 | | 2b. HOUR ^a
6:10 M | | |
| SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 29, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mark P. Pennington | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lulu Wilson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
522-01-6178 | | 17. INFORMANT
ADDRESS
Joan M. Wallace Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4273
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 min
6 days
2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CONGESTIVE HEART FAILURE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>now</u> , 19 <u>78</u> , to <u>Jan 20</u> , 19 <u>81</u> , that (I) <u>was</u> lost
saw the deceased alive on <u>Jan 20</u> , 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated
above, (I) <u>did not</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE
Frank Y. Jaggers | | | | DEGREE
MD | | 22c. DATE SIGNED
January 20, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank Y. Jaggers, M.D. | | | | 22e. ADDRESS
6000 Executive Boulevard
Rockville, Maryland 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
January 21, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL
HOMES, P.A., BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
Arthur M. Brady | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8-1 0 2 5 3 9
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Denis (NMI) McKenna | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/9/81 | | | 2b. HOUR
11:10 PM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
5/4/92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Structural | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9201 Cranford Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Patrick McKenna | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sheila McLaughlin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
029-05-4081 | | 17. INFORMANT
ADDRESS
Sheila Burke 9201 Cranford Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, org. unk
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) multif. deubiliti | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 wk
1 wk
6 mo | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
arteriosclerotic (ose. disease) & hypertension | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from JAN 8 , 19 81 , to 19 81 , that (I) (was) last saw the deceased alive on JAN 8 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Lewis N. Cahill | | | | DEGREE
MD | | | | 22c. DATE SIGNED
1/9/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis N. Cahill | | | | 22e. ADDRESS
5411 Cedar Lane, Bethesda, Maryland 20044 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
January 15, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Benedict Cemetery West Roxbury, Massachusetts | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
Pumphrey | | | |

1984 2 1 ИАН

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 02540

| | | | | | |
|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
SADYE A. McMichael | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
1 16 81 7:00 PM | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
3 2 93 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
87 | |
| 10. CITY OR TOWN OF DEATH
Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa NURSING HOME | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERICAL | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME INS.CO. | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALLAN McMICHAEL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNIE ORSCADDEN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO
088-09-4399 | | 17. INFORMANT ADDRESS
NEPHEW 12544 ARCHERY DRIVE BATON ROUGE, LA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
0389
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) pneumonia, organic brain syndrome
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
pneumonia, organic brain syndrome | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from August 1979 to 1/16 81 , that (1) (we) lost saw the deceased alive on 1/16 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marian M. Chung, M.D. | | | | 22c. DATE SIGNED
1/16/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARIAN M. CHUNG | | | | 22e. ADDRESS
344 University Blvd. W., Silver Spring, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/20/81 | | 23c. NAME OF CEMETERY OR CREMATORY
NORTH CEDAR HILL | |
| 23d. LOCATION CITY OR TOWN
PHILADELPHIA | | COUNTY
PA. | | STATE | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | 25a. DATE RECD. BY REGISTRAR
JAN 22 1981 | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25b. REGISTRAR'S SIGNATURE
Ray Holley | |



RECEIVED
JAN 1 1891
NEW YORK

1891

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102541

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EARL c. McVey | | | 2a. DATE OF DEATH MONTH DAY YEAR
1/14/81 | | 2b. HOUR
8:30 M | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
4 4 95 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DELEWARE | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
WHEATON MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Randolph Hills Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chyle Motor | | 12b. KIND OF BUSINESS OR INDUSTRY
Company | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Wheaton | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4011 Randolph Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas McVey | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Comegys | | 17. INFORMANT ADDRESS
24th & Market | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
221 013915 | | 17. INFORMANT ADDRESS
Spicer-Mullikin F.H. Wilmington, Del | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

ACUTE RENAL FAILUREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**9 DAYS**5849
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CORONARY ARTERY DISEASE, SEVERE PERIPHERAL EDEMA

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14 19 81 , to 1/14 19 81 , that (I) (we) last saw the deceased alive on 1/14 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | |
| 22b. SIGNATURE
David Goldenberg MD | | 22c. DATE SIGNED
1/14/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID GOLDENBERG MD | | 22e. ADDRESS
9801 CEDARDA SILVER SPRING MARYLAND 20902 | |

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1-19-81 | 23c. NAME OF CEMETERY OR CREMATORY
Riverview Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wilmington Delaware |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md. | | 25a. RECEIVED BY REGISTRAR
JAN 19 1981 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

1-2-50

1-2-50

28

28

1-2-50

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02542

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|-------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Edwin Leonel Meadows SR | | | 2a. DATE KNOWN OF DEATH ESTIMATED Jan 17 1981 | | 2b. HOUR 1240
M |
| 3. SEX WM | 4. RACE WM | 5. DATE OF BIRTH Jan 4 1922 | 6. AGE (IN YEARS) 58
MONTHS 00 DAYS 12 HOURS 00 MIN 00 | 7c. DATE PRONOUNCED DEAD Jan 17 1981 | 7d. HOUR 1240
M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Sil. Spg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3225 Medway St | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICAL ENGINEER | |
| 13a. STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Sil. Spg | |
| 14. FATHER'S NAME
FIRST JESSE MIDDLE G. LAST MEADOWS | | 15. MOTHER'S MAIDEN NAME
FIRST MABEL MIDDLE CRUME LAST CRUME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 437-24-5045 | | 17. INFORMANT TIMOTHY MEADOWS | | 17. ADDRESS SAME AS 13 SON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.
(b) Hypertensive Heart Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c) Yrs. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Medical causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | TITLE (SPECIFY) M.D. | | DATE Jan 17 1981 | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS | | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/21/81 | | 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | |
| 23d. LOCATION ROCKVILLE | | 23e. COUNTY MONT | | 23f. STATE MD. | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony M. Kelly | |
| NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | ADDRESS | | | |

MEDICAL CERTIFICATION

NO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

83-54-702

BP_____

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 2 5 4 3

| FOR
1- STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | 3 1 0 2 5 4 3
REG. NO. | |
|---|---------|--|------------------------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH ESTI- MATED | |
| Mary Eva Meidgink | | | | 1981 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY) | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE
PRONOUNCED
DEAD |
| F | W | Nov 2 06 74 | 74 YRS. | | Jan 24 1981 |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Md. | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | |
| St. Mary's | | Hollywood | | Nurse | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Md. | | St. Mary's | | Rt. 2, Box 144-A | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. SOCIAL SECURITY NO. | |
| James Wilson Copsey | | Cordelia Greenwell | | 216-22-3524A | |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 17. INFORMANT | | ADDRESS | |
| No | | Mary Agnes Hunt, Hollywood, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Asphyxiation</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Choking on Food</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>Arteriosclerotic Cardiovascular Disease (Pacemaker)</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| None | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| John L. Rogers | | M.D. Reg | | Jan 24 1981 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | |
| John L. Rogers | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1-27-81 | | St. John's | |
| 23d. LOCATION
CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Hollywood | | St. Mary's | | Md. | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| W. Clarke Mattingley, Leonardtown, Md. | | JAN 29 1981 | | [Signature] | |

0 2 0

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

10-11-1941
10-11-1941
10-11-1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

81 02544

| | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Richard A. Mellen</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1-12-81</i> | | | 2b. HOUR
<i>1:20 PM</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>6 3 00</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
<i>80</i> | | 7. IF UNDER 1 YEAR
HOURS MIN.
<i>120</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Mass.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Colonial Villa Nsg Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Executive</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Boy Scouts</i> | |
| 13a. STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Burtonsville</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Edwin Davis</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Adele Lods</i> | | | 16. STREET ADDRESS
<i>14413 Hollyhock Way</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WWI</i> | | 17. INFORMANT
ADDRESS
<i>270-30-5679A</i> | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

0389

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*minutes**hours*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

metastatic carcinoma, to lung & brain

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <i>January 7, 1981</i> to <i>Jan. 12, 1981</i> , that (I) (we) last saw the deceased alive on <i>Jan 7, 1981</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Marian Chung MD</i> | | DEGREE
<i>MD</i> | | | | 22c. DATE SIGNED
<i>1/12/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MARIAN CHUNG, MD</i> | | 22e. ADDRESS
<i>344 University Blvd., W. Silver Spring, Md.</i> | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Removal</i> | | 23b. DATE
<i>1/12/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
<i>Anatomy Board</i> | | | | ADDRESS
<i>Balto., Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 20 1981</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>John McCreedy</i> | | | |

Copyright Clearance Center

Boy Scouts

1544

244

• **Findings:**

255

252

• B.M. • 215

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

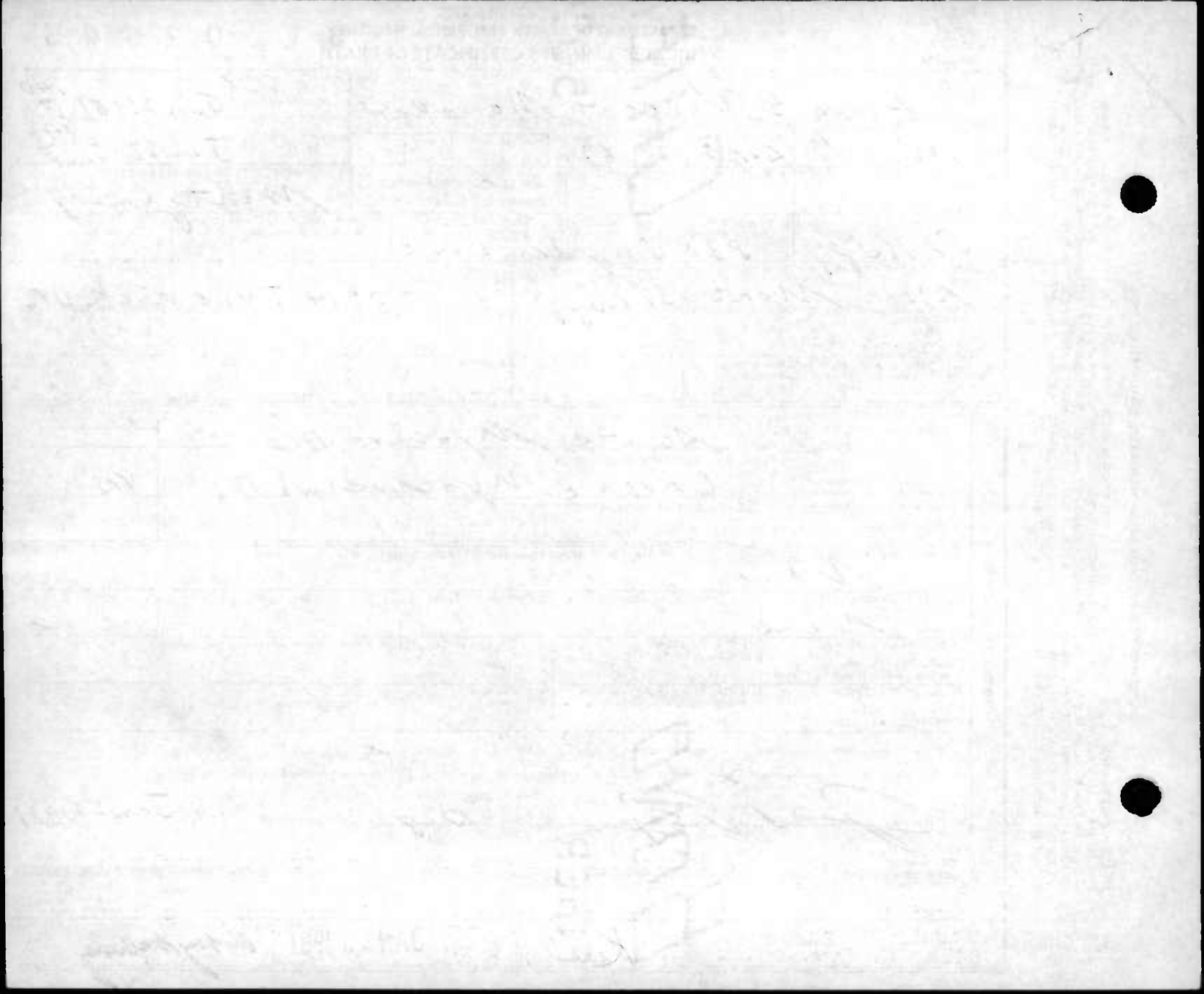
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02545

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|--|-------------------------|---|---|---|------------------|---|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Hubert Vincent Menapace</i> | | | 20. DATE KNOWN OF DEATH
ESTIMATED <i>Jan 22 1981</i> | | | 21. HOUR <i>8</i> M <i>PM</i> | | |
| 3. SEX <i>M</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR <i>Apr. 5 19</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY <i>63</i> YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 21. DATE PRONOUNCED DEAD
MONTH DAY YEAR <i>Jan 22 1981</i> | 21. HOUR <i>8</i> M <i>PM</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD | | |
| 10. CITY OR TOWN OF DEATH
<i>Sr. L. Spg.</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Snider #30 xxxxxxxx Lane</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>U.S. Govt.</i> | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE <i>MD</i> | 13b. COUNTY <i>Mont</i> | 13c. CITY OR TOWN <i>Sr. L. Spg.</i> | | 13e. STREET ADDRESS
<i>32914 Tynewick Dr</i> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Richard Menapace</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Josephine Growski</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i> | | | | |
| 16b. SOCIAL SECURITY NO.
<i>-----</i> | | 17. INFORMANT (wife)
<i>Mary Jane Menapace- (same as 13e)</i> | | 17. ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <i>Chronic Myocardial Dis.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>None</i> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i> | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | TITLE (SPECIFY)
<i>DME</i> | | M.D. <i>12/23/81</i> | | DATE SIGNED
<i>Jan 23 1981</i> | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>John S. Rogers, DME</i> | | ADDRESS
<i>Silver Spring, Maryland</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1-26-1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Silver Spring Montgomery Md</i> | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | ADDRESS
<i>8434 Ga. Ave., S.S. Md.</i> | | DATE REC'D BY REGISTRAR
<i>JAN 29 1981</i> | | REGISTRAR'S SIGNATURE
<i>Anthony M. ...</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Hospital may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02546

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ABRAHAM METELITS | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/25/81 | | 2b. HOUR
MIN.
6:30 M | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 22, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
POTOMAC VALLEY NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
INSURANCE |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND MONTGOMERY SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10500 TENBROOK DRIVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL METELITS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTHER MELNIKOFF | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-20-9721 | | 17. INFORMANT
ADDRESS
IRVIN METELITS SAME AS NO. 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pancreatic carcinoma metastatic metastases
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerotic heart disease implanted pacemaker | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1960 to 1-25-81 , that (I) (we) last saw the deceased alive on 1-23-81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jason Geiger M.D. | | DEGREE
High School | | 22c. DATE SIGNED
1-25-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JASON GEIGER, M.D. | | 22e. ADDRESS
8830 CAMERON STREET SILVER SPRING, MD. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
1/26/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT LEBANON CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI, PR. GEO. MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
DONALD M. STEIN | | HEBREW MEMORIAL F.H.
ADDRESS
232 CARROLL STREET, N. W. WASHINGTON, D. C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 28 1981 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

MEDICAL CERTIFICATION

BP



COLONIAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 4 7

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Albert L. Meyers | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 31 81 | | 2b. HOUR
6²⁰ P.M. |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
1 - 4 - 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Professor Economics | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John H. Meyers | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Doelman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-40-7435 | | 17. INFORMANT
Marjorie C. Meyers same as item #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONITIS
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CONGESTIVE HEART FAILURE, RENAL FAILURE, ARTERIOSCLEROTIC VASC. DIS. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12 , 19 81 , to Jan 31 , 19 81 , that (I) (we) last saw the deceased alive on Jan 31 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bernard A. Fitzgerald | | | DEGREE
MD | | 22c. DATE SIGNED
1-31-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD A. FITZGERALD | | | 22e. ADDRESS
217 UNIVERSITY BLVD EXT SILVER SPRING MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | | 23b. DATE
February 1, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | 23e. DATE REC'D. BY REGISTRAR
FEB 6 1981 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes P.A., Bethesda, Maryland | | | 25. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

2
9

1

0000
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 4 8

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Dorothy L Middleton | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 11 1981 | | | 2b. HOUR
8:30 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 17 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Bethesda Montgomery MD. | | | |
| 12. CITY OR TOWN OF DEATH
Bethesda | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement Center | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House Wife | | 15. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
Md. | | 16b. COUNTY
Montgomery | | 16c. CITY OR TOWN
Chevy Chase | | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16e. STREET ADDRESS
124 Grafton St. | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
Henry Ralph Laing | | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jean Christie | | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
None | | 19b. SOCIAL SECURITY NO.
330 50 9893 | | 20. INFORMANT ADDRESS
Mrs Jean M. Bathurst 124 Grafton St Chv Cha Md 20015 | | | | | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration Pneumonia
4360
DUE TO, OR AS A CONSEQUENCE OF (b) Stroke
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
5 Days | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 22a. DATE OF OPERATION
None | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 22c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 24a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 24b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 24c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 25. I certify that (I) (the hospital) attended the deceased from JAN 6 1981 to JAN 10 1981 , that (I) (we) last saw the deceased alive on JAN 8 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 26. SIGNATURE
John C. Perkins MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 27. DATE SIGNED
1/10/81 | |
| 28. PHYSICIAN'S NAME (TYPE OR PRINT)
D. JOHN C. PERKINS | | | | 29. ADDRESS
5401 Western Ave NW, DC 20015 | | | | | |
| 30. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 31. DATE
11 - 11-81 | | 32. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 33. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 34. FUNERAL DIRECTOR
NAME
Lee Funeral Home 300 4th, St. N.E. Washington D.C. | | | | 35. DATE REC'D. BY REGISTRAR
JAN 6 1981 | | 36. REGISTRAR'S SIGNATURE
[Signature] | | | |

WASHINGTON, D.C. 20540

02

10

10

10

10

Washington, D.C. 20540

U.S.A.

Washington, D.C. 20540

House of Representatives

Department of Justice

Department of Justice

100 Constitution Ave.

Washington, D.C. 20540

Washington, D.C. 20540

Chairman

John

Henry J. Hyde

330 1st St. N.E. Washington, D.C. 20002

Room 330

100 Constitution Ave.

Washington, D.C. 20540

Washington, D.C. 20540

Washington, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

6

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02549

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John D Miles | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 14 1981 | | 2b. HOUR
455 P.M. |
| 3. SEX
Male | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
12 15 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
EDITOR | | 12b. KIND OF BUSINESS OR INDUSTRY
TRANSPORT TOP ICS |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
KENSINGTON | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HUGH MILES | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SUSAN McGRATH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
090-09-6520 | | 17. INFORMANT
ADDRESS
LOLA K. MILES SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Tubular Necrosis 2 weeks
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
12.31.80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aneurysm of Aorta | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12.28. 1980, to 1.14.81, 1981, that (I) (we) last saw the deceased alive on 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
L. Alberto Nunez, MD | | DEGREE
MD | | 22c. DATE SIGNED
1.16.81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
8218 Wisconsin Ave Bethesda MD 20818 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VIRGINIA | | 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
L. Alberto Nunez | | | |

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

15

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 5 0

REG. NO.

| | | | | | | |
|---|--|--|--|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mildred FLORIDA Monck | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-8-81 | | 2b. HOUR
2:32pm | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 8, 1901 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS
HOURS MIN.
0 0 | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH
Takoma Park | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 14. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
Maryland | | 15b. COUNTY
Prince Geo. | | 15c. CITY OR TOWN
Takoma Park | | |
| 16. INSIDE CITY LIMITS?
YES XX NO <input type="checkbox"/> | | 17. STREET ADDRESS
1117 Lancaster Road | | 18. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | |
| 19. KIND OF BUSINESS OR INDUSTRY
Home | | 20. FATHER'S NAME
FIRST MIDDLE LAST
Clarence P. Titter | | 21. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Cavanaugh | | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 23. SOCIAL SECURITY NO.
577-22-1700D | | 24. INFORMANT (Husband)
Gilbert A. Monck | | |
| 25. ADDRESS
SAME AS ITEM # 13 | | 26. CAUSE OF DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Cerebrovascular accident
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerosis | | 27. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| 28. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
ape - | | | | | | |
| 29. DATE OF OPERATION
1/7/81 | | 30. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 31. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 32. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 33. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 34. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10 19 | | |
| 35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 36. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 37. LOCATION
STREET CITY OR TOWN COUNTY STATE
8634 Flower Ave. T. Park Md. | | |
| 38. I certify that (I) (this hospital) attended the deceased from 1/7/81 , 19 81 , to 1/8/81 , 19 81 , that (I) (we) last saw the deceased alive on 1/7/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 39. SIGNATURE
Miguel A. Rodriguez M.D. DEGREE | | 40. DATE SIGNED
1/18/81 | | |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT)
MIGUEL A. RODRIGUEZ | | 42. ADDRESS
8634 Flower Ave. T. Park Md. | | 43. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 44. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 45. DATE
Jan. 10, 81 | | 46. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | |
| 47. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | 48. FUNERAL DIRECTOR
NAME
Hines/Rinaldi | | 49. ADDRESS
11800 N.H. Ave Silver Spring, Md. | | |
| 50. DATE REC'D BY REGISTRAR
JAN 22 1981 | | 51. REGISTRAR'S SIGNATURE
[Signature] | | 52. REGISTRAR'S NAME
[Signature] | | |

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

46
71
35
167
2
2
9
1

5400 BP

1-8-81

1-8-81

1-8-81

1-8-81

1-8-81

1-8-81

Washington Avenue Hospital

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

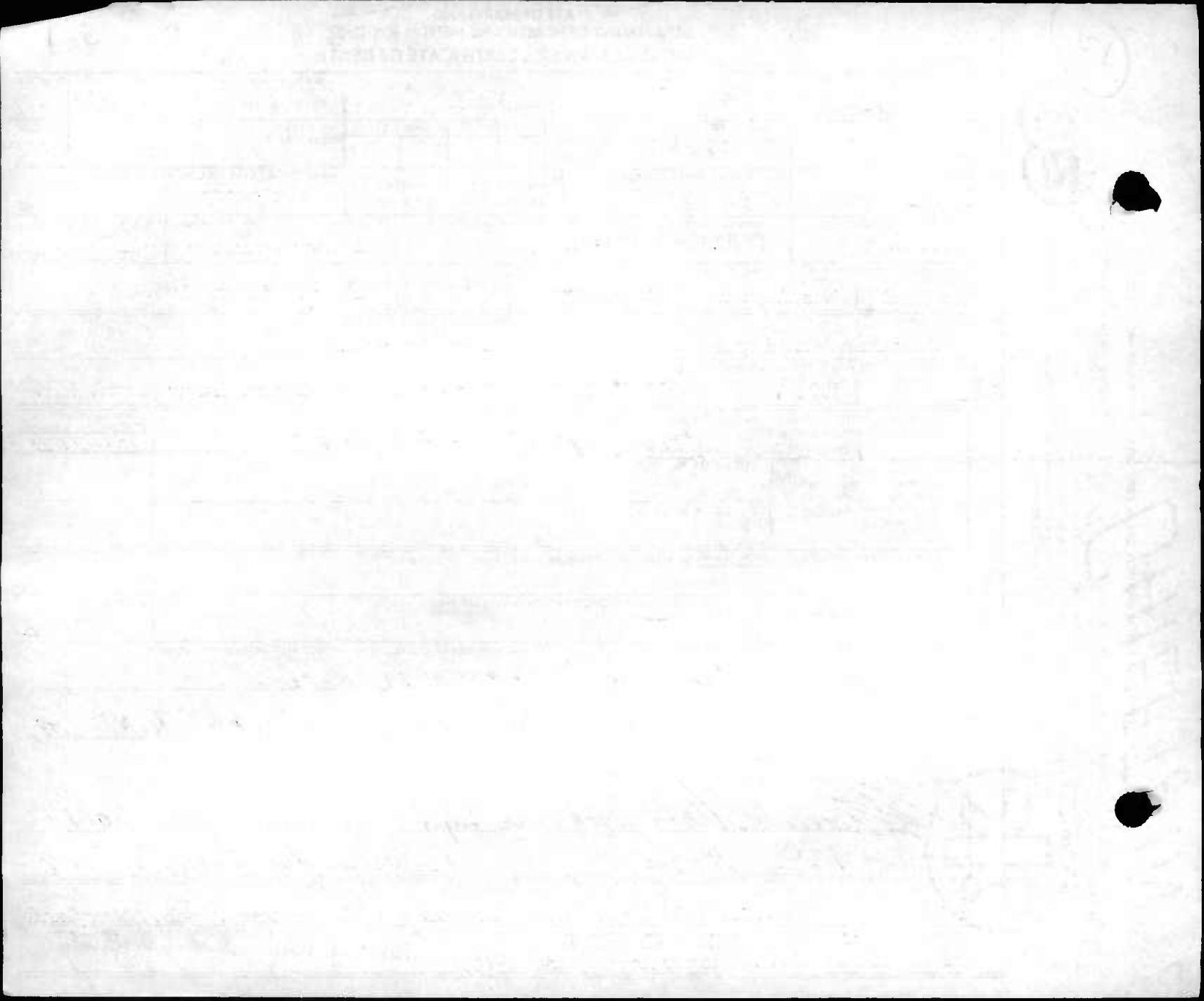
DHM-17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lawrence Edwin Monninger | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
1 20 81
2b. HOUR
3:42AM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
6 18 51 | 6. AGE (IN YEARS)
LAST BIRTHDAY
29 YRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1 20 81
2d. HOUR
3:42AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. |
| 10. CITY OR TOWN OF DEATH
Hyattstown | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
extruder operator | 12b. KIND OF BUSINESS OR INDUSTRY
Certain-teed |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Washington | 13c. CITY OR TOWN
Hagerstown | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
213 W. Wilson Blvd. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jonathan Monninger | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Baker Reel | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1974-75 | | 17. INFORMANT ADDRESS
Teresa M. Monninger, Hagerstown, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MULTIPLE TRAUMA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8169 ACUTE | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
208 1 20 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
CAR OFF OF ROAD - |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
STREET | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
ROUTE 2704109 HYATTSTOWN MONT MD |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | |
| ACTUAL SIGNATURE
P.C. MAYLE | | TITLE (SPECIFY)
M.D. Dyt | | DATE SIGNED
1/20/81 |
| EXAMINER'S NAME
(TYPE OR PRINT)
P.C. MAYLE | | ADDRESS
120 Wisconsin Ave Bethesda MD | | 20014 |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
Jan. 23, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | |
| 24. FUNERAL DIRECTOR
NAME
MINNICH FUNERAL HOME | | 23d. LOCATION
CITY OR TOWN
Hagerstown, Wash., Maryland | | 23e. COUNTY
MONT |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 5 2

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE E. LAST MOON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-23-81 | | | 2b. HOUR
12 ⁴⁰ PM | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 7 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
unknown | | 7b. CITIZEN OF WHAT COUNTRY?
unknown | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
nursing | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
5109 Danbury Road | | 14. FATHER'S NAME
FIRST Unknown MIDDLE LAST | | | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST Unknown MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | | |
| 16b. SOCIAL SECURITY NO.
218 30 3873A | | 17. INFORMANT
ADDRESS
Wm. Bort same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) AORTIC ANEURYSM
DUE TO, OR AS A CONSEQUENCE OF
(b) LEUTIC AORTITIS
DUE TO, OR AS A CONSEQUENCE OF
(c) LEUS | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 yrs
30 "
50 " |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23/81 July 19 80 to 1/23/81, that (I) (we) lost
saw the deceased alive on above, (that I) (we) did not view the body after death and that is (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE
THOS G. WARD | | | | DEGREE | | 22c. DATE SIGNED
1/23/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOS G. WARD | | | | 22e. ADDRESS
6116 ROCKWOOD, Bethesda, Md. 20034 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Wildwood Baptist Church Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Bethesda, Md. | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | 25a. DATE BY REG. 25b. REGISTRAR'S SIGNATURE | | | |

1951 Rockville Pike Rockville, Maryland
Tyson Wheeler, General Agent, Inc.
1951 Rockville Pike Rockville, Maryland

1951 Rockville Pike Rockville, Maryland

x

no -- 518 30 3073A m. Bone name as 195

Unknown
x 5109 Bonbury Road
Unknown

Unknown
x
5109 Bonbury Road
Unknown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Deputy Medical Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8102553 | | | |
|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Willie Virginia Morris | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 12, 1981 | | 2b. HOUR
7:33 PM | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 2, 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montgomery Gaithersburg | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Will ----- Collier | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie ----- Murray | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

579-24-7008A | | 17 INFORMANT ADDRESS
Gaithersburg, Md.
Barbara Samakow; 10116 Little Pond Place | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4276 ventricular fibrillation
DUE TO, OR AS A CONSEQUENCE OF
(b) chronic ventricular ectopy
DUE TO, OR AS A CONSEQUENCE OF
(c) -----
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 minutes
2 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from Jan 12, 1979, to Jan 12, 1981, that (1) (we) lost saw the deceased alive on June 27, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark S. Rosen MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11/13/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark S. Rosen M. D. | | | | 22e. ADDRESS
1131 University Blvd, W. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-15-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24 FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE RECEIVED BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

DHMH-16 25M
(VRA 15, 4) 1/79

Handwritten notes on lined paper, including a circled 'C' at the top left, a circled '13' in the middle left, and a circled '15' in the middle right. The text is mostly illegible due to fading and bleed-through. There are two punch holes on the right side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 5 5 4 | |
|---|--|---|--|---|--|---|--|--|---|--|--|
| REGISTRAR Paul Davis Morrison | | | | | | | | | | CERTIFICATE OF DEATH | |
| FOR STATE REGISTRATION | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Paul Davis Morrison | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 19 81 | | | 2b. HOUR
4 30 AM | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 4 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 | | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Brooke Grove Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stationary Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Salesman | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11524 Deborah Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Morrison | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Kearsley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-09-8774 | | 17. INFORMANT
Mrs. Eleanor M. Moore Same as Item # 13 | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Broncho pneumonia
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Heart failure
(c) Arteriosclerotic CV disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
3 wks
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
9/23 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
19 | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
18111 P. Philip Dr Olney Md 20832 | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/23 1981 to 1/19 1981 , that (I) (we) last saw the deceased alive on 9/23 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see or view the body of the deceased. | | | | | | | | | | | |
| 22a. SIGNATURE
C. H. Ligon | | | | | | DEGREE
MD | | 22c. DATE SIGNED
1/19/81 | | | |
| 22b. PHYSICIAN'S NAME (PRINTED NAME)
C. H. Ligon | | | | | | 22e. ADDRESS
18111 P. Philip Dr Olney Md 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1/22/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 Wisc. Ave. N.W. Wash., D.C. 20016 | | | | | | 25a. DATE RECEIVED BY REGISTRAR
JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
Kerry McHenry | | | |

1. The first part of the paper is devoted to a description of the general character of the country, and to a statement of the principal features of the topography. It is found that the country is generally level, with a few low hills and mountains. The principal features of the topography are the low hills and mountains, and the principal features of the topography are the low hills and mountains.

2. The second part of the paper is devoted to a description of the principal features of the topography. It is found that the country is generally level, with a few low hills and mountains. The principal features of the topography are the low hills and mountains, and the principal features of the topography are the low hills and mountains.

3. The third part of the paper is devoted to a description of the principal features of the topography. It is found that the country is generally level, with a few low hills and mountains. The principal features of the topography are the low hills and mountains, and the principal features of the topography are the low hills and mountains.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 5 5 5

| | | | | | | |
|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James S. Moulden | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 09 81 | | 2b. HOUR
5:13AM | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
January 1 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery Gen. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Govt. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy Yard | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
18 Thomas St., | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Moulden | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ann Thompson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
220-34-4338 | | 17. INFORMANT
ADDRESS
Calphurnia W. Moulden (same as 13e) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1539 IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 MONTHS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT. 24 1980 , to JAN 9, 1981 , that (I) (we) last saw the deceased alive on JAN 3, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Eugene P. Flannery | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/9/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. FLANNERY, MD | | 22e. ADDRESS
18111 PRINCE PHILIP DR-OLNEY, MO-20832 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
1981 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park Rockville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Montgomery Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | ADDRESS
Funeral Homes P/R 300 W. Montgomery Ave., Rockville, Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Eugene P. Flannery | | |

BP

Handwritten signature

JAN 18 1961

AT 1000

Rockville

MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 5 6

REG. NO.

| | | | | | |
|---|--|---|--|---|--------------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Stefanos S. MOUNGELIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 29 81 | | 2b. HOUR
MIN.
1000 P.M. |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
May 15 1893 | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | 12b. KIND OF BUSINESS OR INDUSTRY
Pastry cook | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Stavros | | MIDDLE
MOUNGELIS | 15. MOTHER'S MAIDEN NAME
Maria MYNGOU | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
042 10 3625A | 17. INFORMANT
ADDRESS
Stavros S. MOUNGELIS same as 13e | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK
4402
DUE TO, OR AS A CONSEQUENCE OF
(b) GANGRENOUS RIGHT FOOT
DUE TO, OR AS A CONSEQUENCE OF
(c) ATHEROSCLEROTIC PERIPHERAL VASCULAR DIS. | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

| | | | |
|---|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION
12-29-80 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ISCHEMIC SMALL BOWEL, HERNIA INCARCERATED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-29 , 19 80 , to JAN 29 , 19 81 , that (I) (we) last saw the deceased alive on JAN 29 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Ernest D. Hanowell | | DEGREE
MD | 22c. DATE SIGNED
1/30/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERNEST DALTON HANOWELL | | 22e. ADDRESS
10401 OLD GEORGETOWN RD BETHESDA MD | |

| | | | |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/2/81 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
ADDRESS
1331 Rockville Pike Rockville, Maryland | | 25. DATE REC'D. BY REGISTRAR
FEB 2 1981 | 26. REGISTRAR'S SIGNATURE
 |

1997

10,000'x

x

Library Book

Don't

x

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 5 7 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} <i>Vivian</i> ^{MIDDLE} <i>Roscoe</i> ^{LAST} <i>Mumaw</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 14 1981</i> | | 2b. HOUR <i>9 15</i> M | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Cau.</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>June 28, 1922</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges Montg MD.</i> | |
| 10. CITY OR TOWN OF DEATH <i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Prince Georges</i> | | 13c. CITY OR TOWN <i>Adelphi</i> | | 13e. STREET ADDRESS <i>9274 Adelphi Road, No. 11</i> | |
| 14. FATHER'S NAME ^{FIRST} <i>John Franklin</i> ^{MIDDLE} <i>Georges</i> ^{LAST} <i>Mumaw</i> | | 15. MOTHER'S MAIDEN NAME ^{FIRST} <i>Hamie</i> ^{MIDDLE} <i>Wolverton</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO. <i>223-18-5416</i> | | 17. INFORMANT ADDRESS <i>Hilda Mumaw 9274 Adelphi Road, No. 11 Adelphi, Maryland</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>4310</i>
IMMEDIATE CAUSE (a) <i>Massive Intracranial Hemorrhage</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured cerebral artery</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>6 days</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1/8 81</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>1/8 81</i> to <i>1/14 81</i> , that (I) (we) last saw the deceased alive on <i>1/14 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> DEGREE <i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HUGH IREY</i> | | 22e. ADDRESS <i>11161 N. HAMPSHIRE AVE S.S. MD.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Jan. 18, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Massanutten Cemetery, Woodstock, Shen. Va.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME <i>CAPITOL FUN. SERVICE</i> ADDRESS <i>FAIRFAX VA.</i> | | 25a. DATE RECD. BY REGISTRAR <i>JAN 21 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

Cleared with Medical Examiner
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1207 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 2 | 5 | 5 | 8 |
|--|--|--|---|--|-------------------|--|---|--|--|---|--------------------------------------|-----------------|--|---------------------|---|---|
| 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| James NMN Murdock | | | | | | | | | | 1-20-81 | | | | 10 ⁴⁰ AM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| male | | | white | | | 5-6-87 | | | 93 YRS. | | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | | | |
| New York | | | USA | | | | | | Montgomery | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | | Rockville Nursing Home | | | | | | | minister | | | religion | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| md | | | Mont | | Rockville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 9716 Overlea Dr. | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| James M. Murdock | | | Cornelia Macrae | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | ADDRESS | | | | | |
| NO | | | 577-09-6137 | | | J. H. Murdock (son) | | | | | 9716 Overlea Dr. Rockville, Md 20850 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4100 Coronary Occlusion | | | | | | | | | | 5 min | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | b) Arteriosclerotic Cardiovascular Disease 10 years | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | | |
| cerebrovascular insufficiency | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| none | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | | P.M. none 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from April 22, 1976, to Jan 20, 1981, that (I) (we) last saw the deceased alive on Dec 15, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| Stephen C. Cromwell, M.D. | | | | | | | | | | | | | 1-20-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | |
| Stephen C. Cromwell, M.D. | | | | | | | | | | 615 W. Montgomery, Rockville, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | STATE | | | | |
| Burial | | | 1/22/81 | | | Rockville Cemetery | | | Rockville, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | | | | | | | 25a. DATE RECEIVED BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland | | | | | | | | | | JAN 26 1981 | | | [Signature] | | | |

(M)

James H. Mather, Jr. N. Mather Cornelius Mather

1931 Rockville Pike Bethesda, Maryland
Gordon Wheeler Funeral Home, Inc.

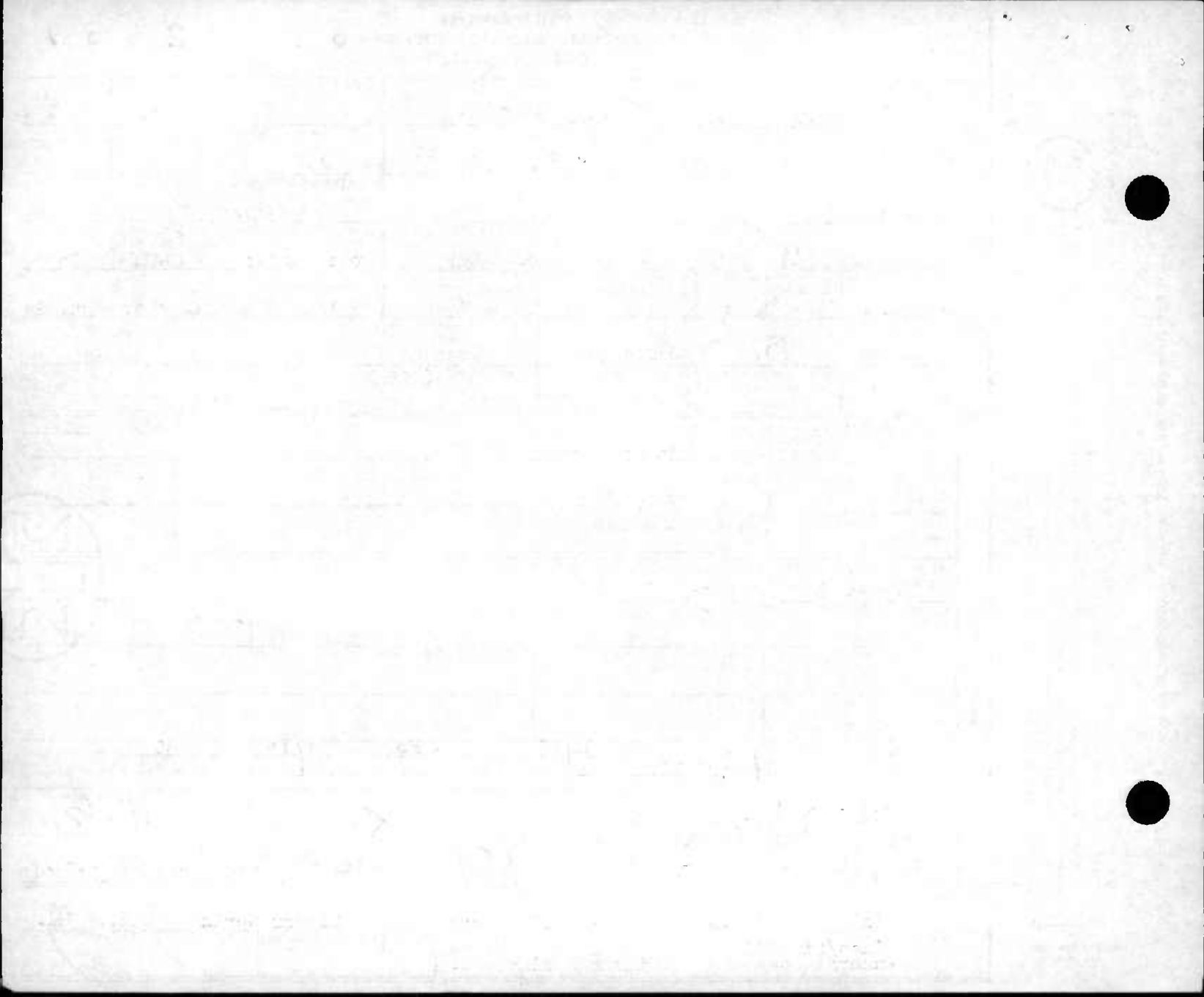
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 81 02559 | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|------------------|--|-----------|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| FIRST MIDDLE LAST
Thomas L. Murtaugh | | | | | | 01-12-81 | | | | | | | | 9 40 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| MALE | | White | | Sept. 22, 1899 | | 81 YRS | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Washington, D.C. | | Yes | | | | Montgomery MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Silver Spring, Md. | | Holy Cross Hospital | | Brick Layer | | Self-Employed | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1400 FENWICK LA. - Apt. 214 | | | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Wife) ADDRESS | | | | | | | |
| Thomas J. Murtaugh | | Frances U. Lewis | | NO | | None | | 214-03-9379 | | Mary E. Murtaugh | | SAME AS ITEM #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal insufficiency | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15, 1980, to 1/12, 1981, that (I) (we) lost the deceased alive on January 12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| Mark H. EUG | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 1/12/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | |
| MARK H. EUG | | | | | | | | | | 9801 GEORGIA AVE SILVER SPRING | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial | | Jan. 15, 1981 | | Gate of Heaven | | Silver Spring, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE FILED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Lines/Rinaldi Funeral Home | | 11800 N.H. Ave. Silver Spring, Md. | | JAN 15 1981 | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
BENNY J NAGRO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-31-81 | | 2b. HOUR
10:34 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
3-16-19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRM Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
S.S. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leon Nagro | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Domenica Lozupone | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WWII 579 14 0038A | | 17. INFORMANT
Blanche F. Nagro (Wife) Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4478 ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 HRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CONGESTIVE HEART FAILURE | | | | | |
| 19a. DATE OF OPERATION
1/29/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AORTILIAC OCCLUSIVE VASCULAR DISEASE | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/3 19 81, to 1/31 19 81, that (I) (we) lost
saw the deceased alive on 1/31 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Louis Kozloff M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/31/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LOUIS KOZLOFF, M.D. | | 22e. ADDRESS
8218 WISCONSIN AVE.
BETHESDA, MD. 20014 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/4/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring Mont. Md. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. REGISTRAR'S SIGNATURE
FEB 4 1981 | | | |
| 24. FUNERAL DIRECTOR
NAME
Dino Amelio | | ADDRESS
11800 N.H.Ave. S.S.Md. | | 25. REGISTRAR'S SIGNATURE | |

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

U. S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

WASHINGTON, D. C.

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02561

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Sophia Nathanson</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>01 12 81</i> | | | 2b. HOUR
<i>5:35 P.M.</i> | |
| 3 SEX
<i>FEMALE</i> | | 4 RACE
<i>WHITE</i> | | 5 DATE OF BIRTH MONTH DAY YEAR
<i>JUNE 24, 1907</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>73</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>POLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE MONT. CO.</i> MD. | |
| 10 CITY OR TOWN OF DEATH
<i>BETHESDA</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>BETHESDA RETIREMENT & NURSING CENTER HOUSEWIFE</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>AT HOME</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MARYLAND</i> | | | | 13b. COUNTY
<i>BALTIMORE</i> | | 13c. CITY OR TOWN
<i>BALTIMORE</i> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>EZEKIEL TERREN</i> | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>ANNA LINST</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO
<i>213-26-6182</i> | | 17 INFORMANT
<i>FRED NATHANSON</i>
<i>11400 DORCHESTER LA., ROCKVILLE, MD 20852</i> | | | |

| | | | | | |
|--|--|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Cardiac-pulmonary arrest</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 week</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Parkinson syndrome</i> | | | | greater than 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>Organic brain syndrome, decub. ulcers on sacrum</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 1980</i> , to <i>Jan 12 1981</i> , that (I) (we) last saw the deceased alive on <i>Jan 8 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Deborah Goldberg</i> | | | | 22c. DATE SIGNED
<i>1/12/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>DEBORAH B GOLDBERG</i> | | | | 22e. ADDRESS
<i>1106 Spring St, Silver Spring MARYLAND</i> | |

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>JAN. 14, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BETH TFILOH</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE MARYLAND</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>SOL LEVINSON & BROS., INC.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 21 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | |

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 6 2

1 - FOR
STATE
REGISTRAR

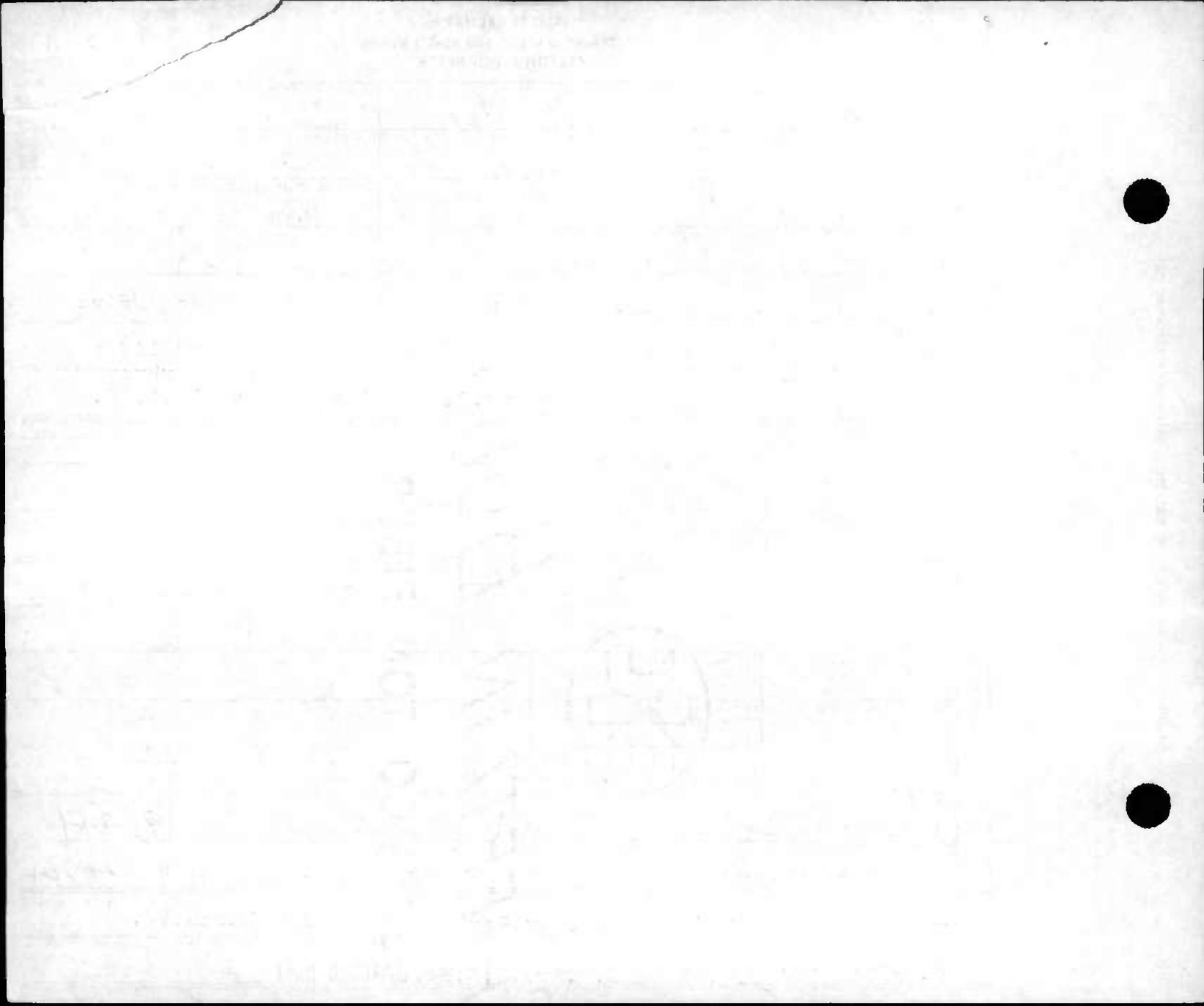
REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Martha Newton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 9, 1981 | | | 2b. HOUR
MIN.
11:00 A.M. | | | | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 26 88 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Life Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11200 Lockwood Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Mottershead | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Elizabeth Radcliffe | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
None | | | 16b. SOCIAL SECURITY NO.
113-22-49870 | | 17. INFORMANT
9039 Sligo Creek Parkway
Mrs. Ray Tuller (Daughter) S.S. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory
5185
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ART unresponsive to therapy
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
For advanced senile dementia and chronic atherosclerotic vascular disease | | | | | | | | | | |
| 19a. DATE OF OPERATION
12-30-80 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
12-30-80 | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
12-30-80 | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
12-30-80 | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
12-30-80 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
11200 Lockwood Dr S.S. Md 20901 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to Jan 9 , 19 81 , that 0 (we) last saw the deceased alive on 12-30-80 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Charles Franklin Jr | | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-19-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles Franklin Jr | | | | | 22e. ADDRESS
11200 Lockwood Dr S.S. Md 20901 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/12/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Nat. Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Va. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE
Dorothy McCurdy | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 81 02563
REG. NO. | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GHINA NIGHTINGALE | | | | 2a. DATE OF DEATH
MONTH JANUARY DAY 7 YEAR 1981 | | | | 2b. HOUR
5:25 P.M. | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DEC. DAY 25 YEAR 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS | | 7 UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHEVY CHASE NURSING & CONVALESCENT CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
CHEVY CHASE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4701 WILLARD AVENUE | |
| 14 FATHER'S NAME
FIRST AVIGDOR MIDDLE LAST RYTMAN | | | | 15 MOTHER'S MAIDEN NAME
FIRST ESTHER MIDDLE LAST MALKA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
053-18-7240D | | 17 INFORMANT
ADDRESS
MONROE MIZEL, 26813 DIX STREET, DAMASCUS, MD. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3352 Amyotrophic lateral sclerosis
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11/75 19 81 , to Jan 7 19 81 , that (I) (we) last saw the deceased alive on 12/5/80 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. M. Evans | | | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/7/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN M. EVANS, M. D. | | | | 22e. ADDRESS
5480 WISCONSIN AVENUE, N. W., WASHINGTON, DC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
1/8/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT LEBANON CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI, PRINCE GEORGES, MD. | | | |
| 24. FUNERAL DIRECTOR
RONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8102564

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|--|-----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ruth E Northedge | | | 2a. DATE OF DEATH
MONTH 1 DAY 09 YEAR 81 | | 2b. HOUR
11:45 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 2 DAY 17 YEAR 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
n/a | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION)
13a. STATE
Maryland | | 13b. COUNTY
Pr Geo | | 13c. CITY OR TOWN
Forestville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Ernest MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST Jane MIDDLE S. LAST Howard | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
578 26 8657 | |
| 17. INFORMANT
Goldie Talbert-Daughter | | 18. ADDRESS
Same as #13 | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4300
IMMEDIATE CAUSE (a) Thrombotic Emboli
DUE TO, OR AS A CONSEQUENCE OF:
(b) Thrombotic Emboli
DUE TO, OR AS A CONSEQUENCE OF:
(c) Subarachnoid Hemorrhage | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hrs
1 wk
2 wks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Emphysema | | | | | | | |
| 19a. DATE OF OPERATION
n/a | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22 19 80 , to 1/9 19 81 , that (I) (we) last saw the deceased alive on 1/9 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James Doyle MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-10-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James J. Boyle MD | | 22e. ADDRESS
5103 Madland Rd Hillandale | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
13Jan1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland PG Md. | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Wilhelm | | FIRM
Funeral Home Inc | | 25a. DATE REC'D BY REGISTRAR
JAN 13 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

Not Released by Dr. Mayle

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CORoner AND DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02565 | |
|---|------------------------|---|---|---|---|---|---|--|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Joseph P O'Connell Jr | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
1 24 1981 | |
| 3. SEX
M | 4. RACE
CAUC | 5. DATE OF BIRTH MONTH DAY YEAR
6 8 23 | 6. AGE (IN YEARS) LAST BIRTHDAY
57 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
1-24-81 | 2d. HOUR
8:45 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Cole | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
INFORM. OFFICER | | 12b. KIND OF BUSINESS OR INDUSTRY
VETS. Adm. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6307 ROCKHURST RD | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOSEPH T. O'CONNELL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
WINIFRED COLLINS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
YES | | | | | 16b. SOCIAL SECURITY NO.
577 40 0637 | | 17. INFORMANT
MARY L. O'CONNELL | | ADDRESS
SAME # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) IRREVERSIBLE HYPOTENSIVE SHOCK
DUE TO, OR AS A CONSEQUENCE OF
(c) ESOPHAGEAL VARICES - CIRRHOSIS
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 MIN
36 HRS
1 YR. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
ETHANOLISM | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 1 12 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
mounting at house | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
6307 ROCKHURST RD BETHESDA MONT | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
6307 ROCKHURST RD BETHESDA MONT MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayle | | | | | | TITLE (SPECIFY)
Asst | | MEDICAL EXAMINER | | DATE SIGNED
1/25/81 | |
| EXAMINER'S NAME (TYPE OR PRINT)
FRANCIS C MAYLE | | | | | | ADDRESS
8200 Wisconsin Ave Bethesda MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
1-27-81 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEM | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
WASH. D.C. | | | |
| 24. FUNERAL DIRECTOR NAME
John F. DeVal | | | | | | ADDRESS
DEVAL FUNERAL HOME WASH. DC | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert H. ... | |

4501
BP
DHMH-17
(VS 115 ME (5))
15M7/77

100-100000

TO THE DIRECTOR, FBI
FROM THE SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report.]

CHIEF

NOTED



Handwritten signature or initials.

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 6 6

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Constance E Offutt | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 9 81 | | 2b. HOUR
MIN.
17 15 PM | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 29 40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
40 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk-typist | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kelly Edwards, Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clementine I. Hill | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
578-60-3630 | |
| 17. INFORMANT
ADDRESS
Darlene Baker (daughter) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Staphylococcal Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Toxic Shock Syndrome | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 min | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 81 to 1/9 19 81 , that (I) (we) last saw the deceased alive on 1/9/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert Millman | | | | DEGREE
MD | | 22c. DATE SIGNED
1/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Millman, MD | | | | 22e. ADDRESS
15 E Drer Park Dr Gaithersburg Md 20760 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPR.D)
Burial | | 23b. DATE
1-16-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montg Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. Wash. St. Rockville, MD. | | 25a. DATE RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAN 16 1981 | |

24. FUNERAL DIRECTOR

NAME

24b. ADDRESS

25a. DATE RECD BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

2101

2102

2103

2104

2105

2106

2107

2108

2109

2110

2111

2112

2113

2114

2115

2116

2117

2118

2119

2120

2121

2122

2123

2124

2125

2126

2127

2128

2129

2130

2131

2132

2133

2134

2135

2136

2137

2138

2139

2140

2141

2142

2143

2144

2145

2146

2147

2148

2149

2150

2151

2152

2153

2154

2155

2156

2157

2158

2159

2160

2161

2162

2163

2164

2165

2166

2167

2168

2169

2170

2171

2172

2173

2174

2175

2176

2177

2178

2179

2180

2181

2182

2183

2184

2185

2186

2187

2188

2189

2190

2191

2192

2193

2194

2195

2196

2197

2198

2199

2200

2201

2202

2203

2204

2205

2206

2207

2208

2209

2210

2211

2212

2213

2214

2215

2216

2217

2218

2219

2220

2221

2222

2223

2224

2225

2226

2227

2228

2229

2230

2231

2232

2233

2234

2235

2236

2237

2238

2239

2240

2241

2242

2243

2244

2245

2246

2247

2248

2249

2250

2251

2252

2253

2254

2255

2256

2257

2258

2259

2260

2261

2262

2263

2264

2265

2266

2267

2268

2269

2270

2271

2272

2273

2274

2275

2276

2277

2278

2279

2280

2281

2282

2283

2284

2285

2286

2287

2288

2289

2290

2291

2292

2293

2294

2295

2296

2297

2298

2299

2300

2301

2302

2303

2304

2305

2306

2307

2308

2309

2310

2311

2312

2313

2314

2315

2316

2317

2318

2319

2320

2321

2322

2323

2324

2325

2326

2327

2328

2329

2330

2331

2332

2333

2334

2335

2336

2337

2338

2339

2340

2341

2342

2343

2344

2345

2346

2347

2348

2349

2350

2351

2352

2353

2354

2355

2356

2357

2358

2359

2360

2361

2362

2363

2364

2365

2366

2367

2368

2369

2370

2371

2372

2373

2374

2375

2376

2377

2378

2379

2380

2381

2382

2383

2384

2385

2386

2387

2388

2389

2390

2391

2392

2393

2394

2395

2396

2397

2398

2399

2400

2401

2402

2403

2404

2405

2406

2407

2408

2409

2410

2411

2412

2413

2414

2415

2416

2417

2418

2419

2420

2421

2422

2423

2424

2425

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02567

REG. NO.

| | | | | | | | |
|--|--|---|---|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>BESSIE Osberg</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>January 10, 1981</i> | | 2b. HOUR
<i>4:11 AM</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Oct. 4, 1884</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>96</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Russia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY County MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>NOTY CROSS Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>-----</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
<i>6121 Montrose Road</i> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Abraham ----- Newman</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Fanny ----- Firestone</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | |
| 16b. SOCIAL SECURITY NO.
<i>214-74-3660</i> | | 17. INFORMANT
<i>Farrell R. Werbow;</i> | | ADDRESS
<i>Falls Church, Va.
3404 Stoneybrae Dr</i> | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiomyopathy and</i>
<i>4140</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Chronic Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arteriosclerotic Heart Disease</i> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>1 week</i>
<i>Sym.</i> |
|--|--|---|

| | | | |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Renal failure.</i> | | | |
| 19a. DATE OF OPERATION
<i>2/9</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <i>JULY 1978</i> to <i>JAN 10 1981</i> , that (I) (we) last saw the deceased alive on <i>JAN 9 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE <i>Robert L. Rosenberg, M.D.</i> DEGREE <i>MD</i> | |
| 22c. DATE SIGNED <i>1/10/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT L. ROSENBERG, M.D.</i> | |
| 22e. ADDRESS <i>1131 UNIVERSITY BLVD W. SILVER SPRING, MD</i> | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1-11-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Har Nebo Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Philadelphia, Pa.</i> | |
|--|--|-----------------------------|--|--|--|--|--|

| | | | | | | | |
|--|--|---------------------------------------|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
<i>Danzansky-Goldberg Chapels;</i> | | ADDRESS
<i>1170 Rockville Pike</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 13 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCreedy</i> | |
|--|--|---------------------------------------|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 02568 | | | | | | | |
|--|--|------------------------|--|---|--|--|--|---|--|------------------|--|--|--|-----------------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) THEODORE W. OUSLEY | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH
EST. MATED <input checked="" type="checkbox"/> 1/23/81 | | 2b. HOUR
P M | | | | | |
| 3. SEX
M | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH DAY YEAR 3 11 12 | | 6. AGE (IN YEARS)
LAST, BIRTHDAY YRS. 68 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1 23 1981 | | 2d. HOUR
M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MINN. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
GAITHERSBURG | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
853 DIAMOND DR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
FARMER | | | | 12b. KIND OF BUSINESS OR INDUSTRY
FARMER | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY
MONTGOMERY | | | | 13c. CITY OR TOWN
GAITHERSBURG | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
853 DIAMOND DR | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alvah B. Ousley | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary - Ballard | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WW II 543-12 2973 | | | | 17. INFORMANT
John W. OUSLEY | | | | ADDRESS 853 DIAMOND DR. GAITHERSBURG, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
5621 IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF
(b) DIVERTICULOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 8-10 yrs | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
- | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1 23 1981 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FOUND DEAD AT HOME | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
853 DIAMOND AVE GAITHERSBURG MONT MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle | | | | | | TITLE (SPECIFY) Sgt M.D. MEDICAL EXAMINER | | | | | | DATE SIGNED 1/24/81 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE | | | | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
1/24/81 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | | | | | | |
| 24. FUNERAL DIRECTOR (NAME)
GARTNER SANDISON F.H. Gaithersburg, Md. | | | | | | 25. DATE RECEIVED BY REGISTRAR
JAN 8 1981 | | | | | | 26. REGISTRAR'S SIGNATURE | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8102569 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Myrtle Padgett | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/4 19 81 | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR Aug. 16, 1889 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 91 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1/4 19 81 | | 2b. HOUR
1:05 | | 2d. HOUR
1:05 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
=Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Randolph Hills Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | | | | | | |
| 13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3703 Chevy Chase Lake Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry T. Padgett | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hester Deakins | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
263-80-0739 | | | | | 17. INFORMANT
ADDRESS
Louise Moran, Same as item #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) generalized arteriosclerosis.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Fracture of right hip. | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
4/18/80 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fracture of right hip. | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4/17 1980 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell on street. | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Street | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Randolph Road, Silver Spring, Montgomery, Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
M.D. Deputy MEDICAL EXAMINER | | | | DATE SIGNED 1/4/81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | | ADDRESS
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
January 7, 1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY
All Hallows Episcopal Chapel Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Davidsonville, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Homes, P.A., Bethesda, Maryland | | | | 24. FUNERAL DIRECTOR ADDRESS
Robert A. Bumphrey Funeral | | | | DATE RECD. BY REGISTRAR
JAN 12 1981 | | | | REGISTRAR SIGNATURE
<i>Patricia McBrady</i> | | | | | | | |

BP

DHMH-17
(V.R. 7/76)
15M 7/76

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 5 7 0 | |
|---|--|---|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) William Pappas (Papannicolao) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-4-81 | | | | | 2b. HOUR 9:35 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 28 93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Furrier | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1320 Gresham Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Demetrios Papannicolao | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 088-07-9510A | | 17. INFORMANT ADDRESS Despina Pappas (wife) - Same as 13 e. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Influenza pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration
DUE TO, OR AS A CONSEQUENCE OF (c) Hypotension | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3-81 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Respiratory insufficiency, Left Cerebrovascular Accident | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-21-80 , 19____, to 1-4-81 , 19____, that (I) (was) lost saw the deceased alive on 1-4-81 , 19____, and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE G.B. Patrick MD | | | | | DEGREE MD | | | | | 22c. DATE SIGNED 1-4-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.B. Patrick MD | | | | | 22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE January 7, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md. | | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi FH | | | | | ADDRESS 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | REGISTRAR'S SIGNATURE [Signature] | | |

1-1-1

RECEIVED
JAN 1 1981

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 7 1

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Madge A. Parker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/5/81 | | | 2b. HOUR
8:45 M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-19-18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
2212 PARKER AVENUE | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARTHUR L. CORNES | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SUSIE LINSOTT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
234-14-9998 | | 17. INFORMANT
ADDRESS
JOHN M. PARKER SAME AS 13 HUSBAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) Breast Cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-4 wks
20 yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pleural Effusion Malignant | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 19 76 to Jan 19 81 , that (I) (we) last saw the deceased alive on 5 Jan 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Eugene P. Libro MD | | | | DEGREE
MD | | 22c. DATE SIGNED
6 JAN 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Eugene P. Libro | | | | 22e. ADDRESS
10400 Conn. Ave. Kensington MD 20795 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT MD | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REG'D. BY REG. OFFICER
JAN 12 1981 | | | |
| ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 1. 1.

RECEIVED
JAN 1 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02572

| | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------------------|--|--|--|---|--|---|--|---|--|---|--|--------------------|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>Christine</i> | | MIDDLE
<i>Parry</i> | | LAST | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> <i>Jan 16 1981</i> | | MONTH
<i>12</i> | | DAY
<i>16</i> | | YEAR
<i>1981</i> | | 2b. HOUR
<i>12:00</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH
<i>Dec</i> DAY
<i>25</i> YEAR
<i>1937</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>93</i> YRS. | | IF UNDER 1 YR.
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | 2c. DATE PRONOUNCED DEAD
<i>Jan 16 1981</i> | | MONTH
<i>12</i> | | DAY
<i>16</i> | | YEAR
<i>1981</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Ohio</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Sal Spz</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hosp</i> | | | | | | | | 12a. USUAL OCCUPATION (TYPE OR INDUSTRY)
<i>Clerk</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Fed. Gov't</i> | | | |
| 13a. STATE
<i>MD</i> | | | | 13b. COUNTY
<i>Mont. Kensington</i> | | | | 13c. CITY OR TOWN
<i>4210 Brookfield Dr</i> | | | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 13e. STREET ADDRESS | | | |
| 14. FATHER'S NAME
FIRST
<i>John</i> | | | | MIDDLE
<i>Weber</i> | | | | LAST
<i>Mary</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Mary</i> | | | | MIDDLE
<i>Kassmann</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO.
<i>577-12-6623</i> | | | | 17. INFORMANT
ADDRESS | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Cardiac Arrest</i>
(b) <i>Fracture Rt. Hip</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
<i>88880</i> | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>7 days</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<i>None</i> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>1-15-81</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
<i>Fracture Rt Hip</i> | | | | | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>01 7 1981</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
<i>Fell in her room</i> | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
<i>Nursing Home</i> | | | | 21f. LOCATION
STREET
<i>Montgomery</i> CITY OR TOWN
<i>Adolph Prince George</i> COUNTY
<i>MD</i> STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Robert J. Rogers</i> M.D. | | | | TITLE (SPECIFY)
<i>Web</i> MEDICAL EXAMINER | | | | | | | | | | | | | | DATE SIGNED
<i>Jan 16 1981</i> | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Removal</i> | | | | 23b. DATE
<i>1/16/81</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Anatomy Bored</i> | | | | ADDRESS
<i>655 W. Baltimore St.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 26 1981</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McCreary</i> | | | | | | | |



U.S.

Ohio

Eng. 101.2

Class

Engineering

Math

Physics

Chem

2533-11-113

10

10001

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 7 3 | | | |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ELIZABETH MAE PAUL | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-2-81 | | 2b. HOUR
9¹⁰ P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
5-12-89 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Ph. Geo. 13c. CITY OR TOWN W. Hyattsville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7303 23rd Avenue | |
| 14. FATHER'S NAME
FIRST Felix MIDDLE Boyce LAST Boyce | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Mulherin LAST Mulherin | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16a. SOCIAL SECURITY NO.
213-54-8940 | | 17. INFORMANT
son | | 17. ADDRESS
Frederick M. Paul same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Circulatory Collapse
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia - Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(c) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 hrs
3-4 days
1-2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 1973 to Jan 2 1981 , that (I) (we) last saw the deceased alive on Jan 2 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert B. Irey | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-3-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT B. IREY | | 22e. ADDRESS
11161 New Hampshire Ave Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Ph. Geo. Md. | |
| 24. FUNERAL DIRECTOR
NAME Francis J. Collins ADDRESS
500 University Boulevard, W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1981 | | 25b. REGISTRAR'S SIGNATURE
R. J. McBrady | | | |

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

Pennsylvania
 John F. Kennedy
 Washington, D.C.
 20503
 22nd Avenue
 Washington
 Police
 913-24-2947
 Frederick M. Paul
 13

204 University Boulevard N.
 Silver Spring, Md.
 Frederick M. Paul
 13

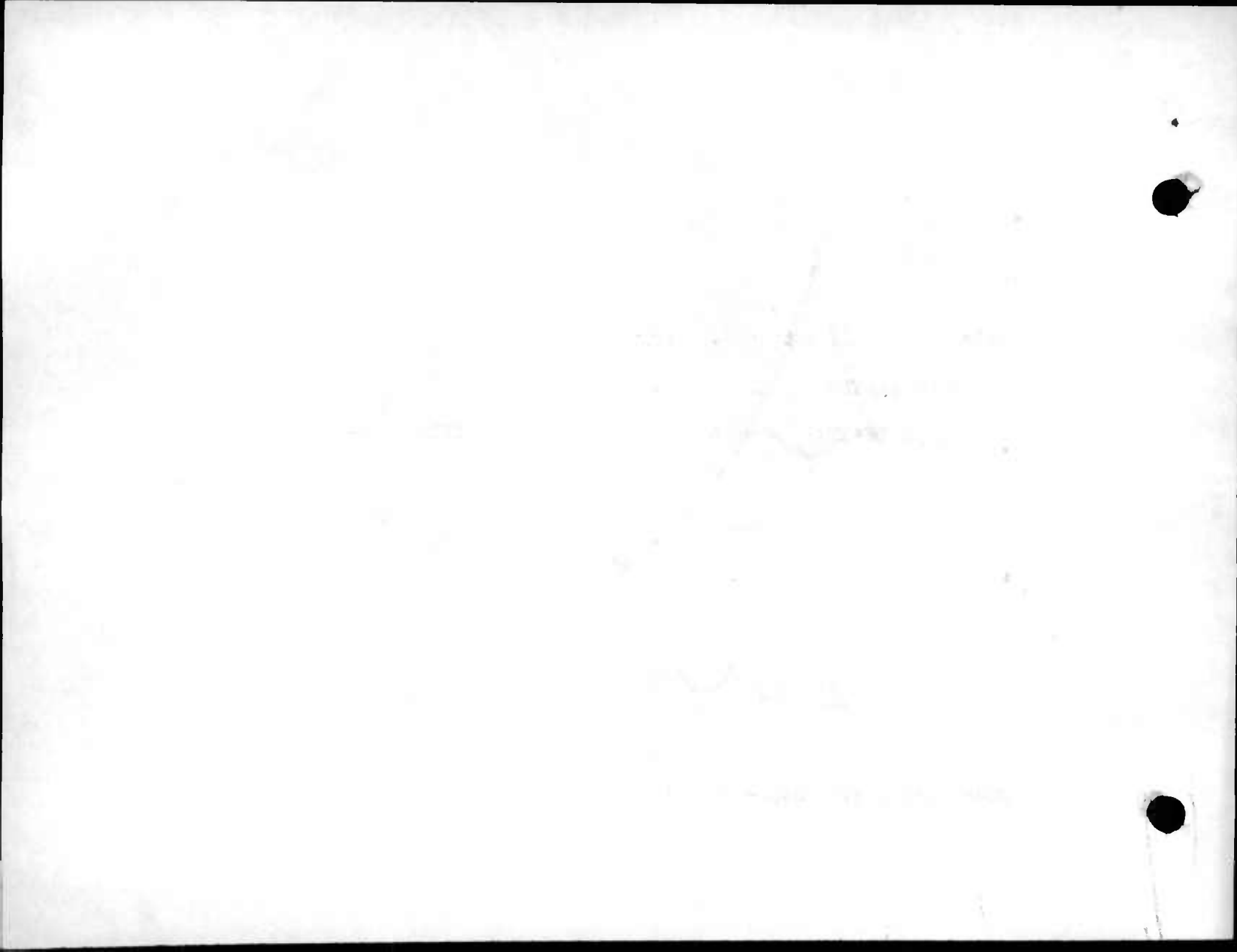
NAME: Christine W. Perry

DATE OF DEATH: January 16, 1981

PLACE OF DEATH: Montgomery County

SEE: #81-02572

DEMh 2485 - Vit. Rec.



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

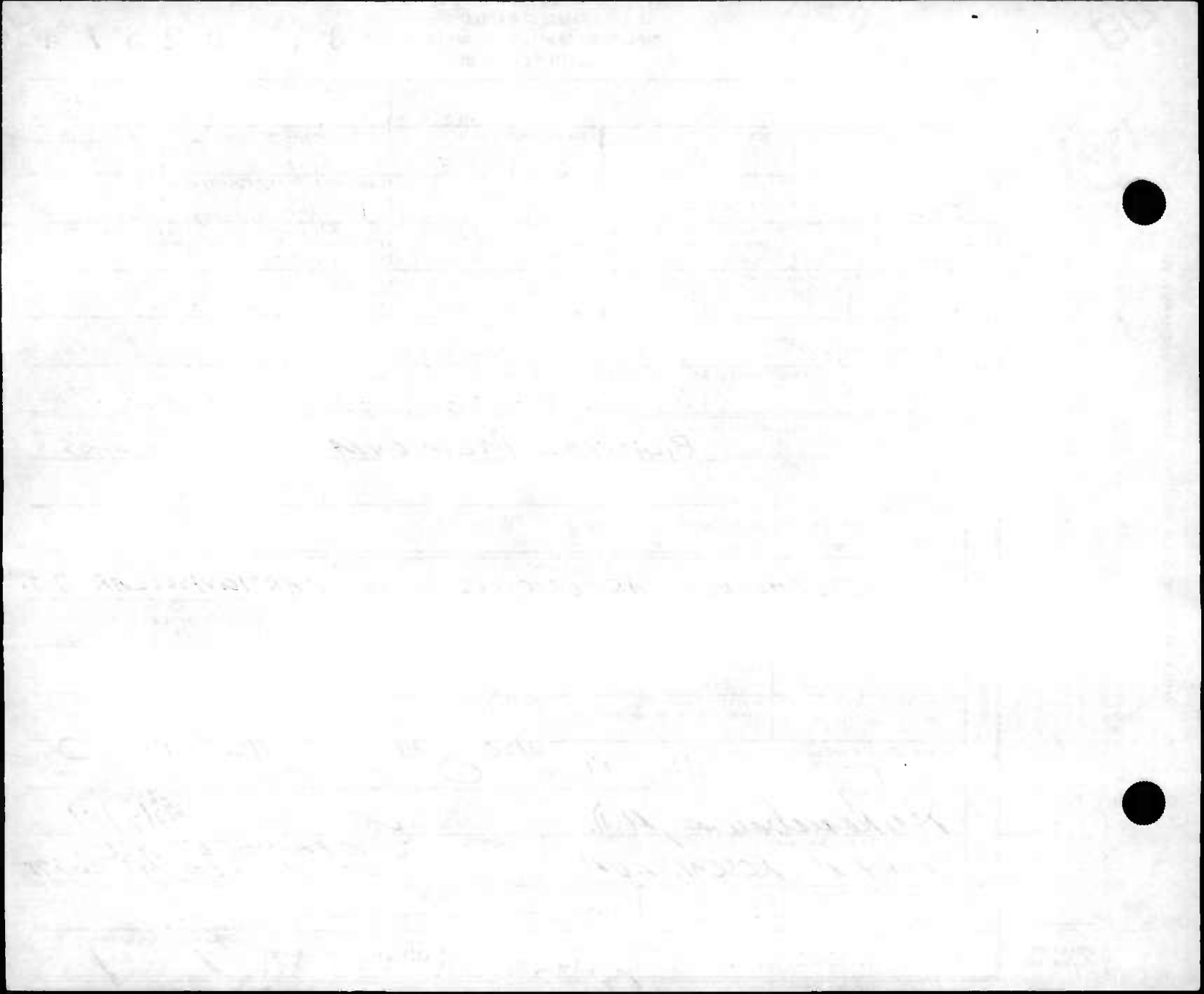
81 02574

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Giuseppina Petrone | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 2 1981 | | 2b. HOUR
345 M |
| 3 SEX
Female | 4 RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
3 19 86 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kensington Gardens Nsg. Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
D.C. | | 13b. COUNTY
13c. CITY OR TOWN
Wash. D.C. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1624 Underwood St. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Antonio Fucci | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Pilla | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
None | | 16b. SOCIAL SECURITY NO
579-46 9038 | | 17. INFORMANT
Same as above
Joseph Urciolo (Son-in-law) |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BILATERAL PNEUMONIA</u>
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 WKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>79</u> , to <u>1/2</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
<u>Rosenbaum, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/2/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY N. ROSENBAUM | | 22e. ADDRESS
3720 FARRAGUT AVE.
KENSINGTON, MD 20795 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1/6/81 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Va. |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1981 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 2 5 7 5 | | | |
|---|--|--|--|---|--|---|--|---|--|---|---|--|--|--------------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Arthur Harvey Phipps</i> | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>January 26, 1981</i> | | | | 2b. HOUR
<i>7/4</i> M | |
| 3. SEX
<i>Male.</i> | | 4. RACE
<i>White.</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Nov. 17, 1904</i> | | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
<i>76</i> | | IF UNDER 1 YEAR MONTHS DAYS
<i>76</i> | | IF UNDER 24 HRS. HOURS MIN.
<i>76</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD.</i> | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>G. S. A. Chief Painter.</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Govnt.</i> | | | | | |
| 13a. STATE
<i>Maryland.</i> | | | | 13b. COUNTY
<i>Montg.</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>15300 Wallbrook Ct. 20906</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>R. Henry Phipps.</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Selena Walter.</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No.</i> | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
<i>705-14-9377</i> | | 17. INFORMANT ADDRESS
<i>M. Rubye S. Phipps. (Wife) 13 e</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Upper GI bleeding</i>
<i>1629</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gastric Ulcer</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer rt upper lung Squamous cell</i>
<i>1 1/2 yrs</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1-2 days</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Recent MI - Cong Heart Failure - atrial fibrillation - Arteriosclerosis</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>April 79</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Cancer rt lung - biopsy</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 11, 1981</i> to <i>Jan 26, 1981</i> , that (I) (we) last saw the deceased alive on <i>Jan 11, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>R.H. Sandstrom MD</i> | | | | DEGREE
<i>MD</i> | | | | 22c. DATE SIGNED
<i>1-26-81</i> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>R. H. Sandstrom MD</i> | | | | 22e. ADDRESS
<i>7701 Carroll Ave Takoma Park, Md</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Jan. 29, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft. Lincoln</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Bladensburg, P. Geo. MD.</i> | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME
<i>Arthur Phipps</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 29 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur Phipps</i> | | | | | | | | | |
| 25c. ADDRESS
<i>254 Carroll St. N. W. D. C.</i> | | | | | | | | | | | | | | | |

BP

• *Journal of the American Medical Association*, 1997; 277: 1033-1037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>Item 5 8555 5/13/81</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>2 5 7 6</div> | | | | | | | | | | | |
|---|--|---------|--|--------------------------------|--|---|---------------------------------|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Jean | | | Pierce | | | January 21 1981 | | | 1:35a M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female. | | White. | | Jan. 21, 1981
July 18, 1988 | | | 92 YRS | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Jersey City | | | U. S. A. | | | | | | Montgomery County Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Olney | | | Sharon Nursing Home | | | Homemaker. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived at institution: Residence before admission) | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Maryland. | | | Beltsville. | | | YES | | | 11605 34 th. Place. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Henry | | | Neblung. | | | Josephine | | | Latour. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No. | | | 154-38-8252 | | | Helen S. Porter. | | | (Daughter) 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrest secondary to arrhythmia | | | | | | | | | | Sudden | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | Unknown | |
| (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Diabetes mellitus | | | | | | | | | | Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 15, 1974, to January 21, 1981, that (I) (we) last saw the deceased alive on January 21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| Carl J. Houmann | | | | | | M.D. | | | January 21, 1981 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Carl J. Houmann, M.D. | | | | | | 4404 Queensbury Rd., Riverdale, Md. 20840 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Cremation. | | | Jan. 23, 1981 | | | Ft. Lincoln | | | Bladensburg Rd. P. G. Md | | |
| 23e. FUNERAL DIRECTOR | | | 23f. ADDRESS | | | 23g. REC'D BY REGISTRAR | | | 23h. REGISTRAR'S SIGNATURE | | |
| Arthur Walters | | | 254 Carroll St. N. W. D. C. | | | JAN 26 1981 | | | History McBrady | | |
| | | | Takoma Funeral Home. | | | | | | | | |



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02577

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PORZIA R. PISANI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-9-81 | | | 2b. HOUR
11:15 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT-10-1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
96 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10825 Childs STREET | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vito R. Rubino | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes UNK | | | 16. STREET ADDRESS
10825 Childs STREET | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
None | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579 03 2939 | | 17. INFORMANT
Anthony Pisani (Son) | | | ADDRESS Same as above | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive failure
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Arteriosclerosis
(c) Generalized arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
10 yrs. | |
|--|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 70 , to Jan 9 19 81 , that (I) (we) last saw the deceased alive on Jan 9 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ralph F. Patten MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-9-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RALPH F. PATTEN MD | | 22e. ADDRESS
1407 Modale Parkway Silver Spring Md | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/13/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland PG Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi F.G. | | | | ADDRESS
H. 11800 N.H. Ave. S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 22 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Ralph F. Patten | | | |

11250 4-8 1981

1981 11 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| FOR
1. STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 7 8
REG. NO. | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Victor | | | | FIRST MIDDLE LAST Pittle | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-18-81 | | | | 2b. HOUR 6 P.M. | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR 12 15 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 | | # UNDER 1 YEAR
MONTHS DAYS | | # UNDER 1 YEAR
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MONTGOMERY GENERAL HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
CLAIMS. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
21711 GEORGIA AVE BROOKEVILLE. | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY MONTG. | | 13c. CITY OR TOWN BROOKVILLE | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST SAMUEL ----- PITTLE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST RACHAEL ----- WISOTZKI | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 579-32-6801 | | 17. INFORMANT
ADDRESS MRS. SHIRLYE PITTLE 21711 GEORGIA AVE. BROOKEVILLE MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST
4149
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
MINUTES
10 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
----- | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
----- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
----- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. ----- 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
----- | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
----- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
----- | | | | | | | | | |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>January 16, 1981</u> to <u>January 18, 1981</u> , that (I) <u>lost</u> saw the deceased alive on <u>January 16, 1981</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Stanley W. Kirshten, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1-19-81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STANLEY W. KIRSTEIN, M.D. | | | | 22e. ADDRESS
5410 CONN. AVE, N.W. DC 20015 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
1-20-81 | | 23c. NAME OF CEMETERY OR CREMATORY
JUDEAN MEM. GARDENS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OLNEY MONT. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEM. CHAP | | | | 1170 ROCKVILLE
ROCKVILLE MD. PK. | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

6 V C

9 2

12-81-1

2-1-1

2-1-2

3-1-1

12-81-1

12-81-1

12-81-1

12-81-1

12-81-1

12-81-1

12-81-1

12-81-1

12-81-1

12-81-1

MEDICAL CERTIFICATION

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15.4)

Washington, D. C. 20540
The Honorable
U. S. House of Representatives
Room 1215
Washington, D. C. 20540
Dear Mr. [Name]
I am pleased to hear from you and to learn that you are interested in the work of the [Organization].

The [Organization] is a non-profit organization dedicated to the [Mission]. We are currently seeking individuals who are passionate about [Cause] and who are willing to commit their time and energy to our work. If you are interested in learning more about our organization and the opportunities available, please contact me at [Phone Number] or [Email Address].

I am sure that you will find our work to be both challenging and rewarding. We are a team of dedicated professionals who are committed to making a difference in the world. We are currently looking for individuals who are motivated, organized, and have excellent communication skills. If you are interested in joining our team, please send me your resume and a letter of interest. We will review your application and contact you if we are interested in moving forward.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 8 0

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
GRAFTON EUGENE POOLE | | | 2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 2, 1981 | | 2b. HOUR
453 A M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 11, 1922 | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | 12b. KIND OF BUSINESS OR INDUSTRY
Accounting | |
| 13a. STATE
MD | | | 13b. CITY OR TOWN
Washington DC | | |
| 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS
3726 Connecticut Ave. N.W. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick Poole | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Shotroff | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WWII 579 10 4576 | | 17. INFORMANT
Wife
Goldie A. Poole same as item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Irreversible Respiratory Failure
1509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Irreversible Bilateral Pulmonary Interstitial Pneumonia
(c) Adenocarcinoma of the Esophagus | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours
35 days
undetermined |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Inanition, Malnutrition | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from November 28, 1980 , to January 2, 1981 , that (1) we lost
saw the deceased alive on January 2, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (1) we (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
James E. Wilson, Jr. | | DEGREE
M.D. | | 22c. DATE SIGNED
1/2/81 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
James E. Wilson, Jr. M.D. | | 22e. ADDRESS
11125 Rockville Pike, Rockville, Md. 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Jan. 6, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Monocacy Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Beallsville, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1981 | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

NOV. 11, 1932

Mr. J. H. ...

Dear Sir:

I am ...

Very ...

Sincerely,

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 18b.&18c.

1. FOR STATE REGISTRAR al
Film#G552 2-9-81STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 8 1

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|-----------------------------|---|--|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDNA MAE PORTER | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN. 4 1981 | | 2b. HOUR
12:38 PM | | | | | | |
| 3 SEX
F. | | 4 RACE
W | | 5 DATE OF BIRTH MONTH DAY YEAR
4 23 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS | | 7 UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Brookville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
20910 New Hampshire Ave. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Cecil Johnson | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Floyd | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
None | | | | 16b. SOCIAL SECURITY NO
400 14 0005 | | 17 INFORMANT ADDRESS
Jean Shields (Daughter) Same as above | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c);
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **5789**
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

Acute Tubular Necrosis

(b)

DUE TO, OR AS A CONSEQUENCE OF

G-I Hemorrhage & Shock

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1/79 to 1/4/81 , that (I) (we) last saw the deceased alive on 1/4/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE
Howard W. Penney, M.D. | | | | DEGREE | | 22c. DATE SIGNED
1/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard W. Penney, M.D. | | | | 22e. ADDRESS
115 Spring Street
Baltimore, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wash. D.C. | |
| 24 FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | | ADDRESS
11800 N.H. Ave.
S.S.Md. | | 25a. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
[Signature] | |

10050

RECEIVED
FEB 10 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02582

1- STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| GERALD EDWARD POSTON | | | MONTH DAY YEAR | | | 9:03 | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | |
| Male | | | White | | | June 11 1928 | | |
| 6. AGE (IN YEARS) | | | IF UNDER 1 YR. | | | IF UNDER 24 HRS. | | |
| 56 YRS. | | | MONTHS DAYS HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Indiana | | | USA | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| S.S. | | | Holy Cross Hospital | | | State of Md. Employer | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | Montgomery | | | Silver Spring | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| Samuel Poston | | | Emma Devine | | | 315 14 1375 | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Brad Poston (Son) | | | 4291 Acute myocardial infarction | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| None | | | None | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. DATE | | | 22c. NAME OF CEMETERY OR CREMATORY | | |
| 1/15/81 | | | Lee's Creamtory | | | 22d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Cremation | | | 1/15/81 | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md. | | | JAN 15 1981 | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and concurrently filed in my office, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 8 3
REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST Jean MIDDLE M. LAST Power
JEAN M. POWER | | | | 2a. DATE OF DEATH MONTH 1 DAY 29 YEAR 81 | | | | 2b. HOUR 6:15 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH Aug. DAY 21 YEAR 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fernwood House Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | | | |
| 13a. STATE
--- | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Washington, D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2853 Ontario Road, N.W. | | | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE --- LAST Power | | | | 15. MOTHER'S MAIDEN NAME FIRST Sara MIDDLE --- LAST Peterson | | | | ADDRESS Bethesda, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO
--- | | 17. INFORMANT Joseph A. Rafferty, 4701 Sangamore Road | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4299 IMMEDIATE CAUSE (a) Acute Cardiovascular Collapse
DUE TO, OR AS A CONSEQUENCE OF (b) 1 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
81 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
81 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
1/29 81 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21 19 81 , to 1/29 19 81 , that (I) (last) saw the deceased alive on 8/21 19 81 , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above; (d) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. Blaine Fitzgerald | | | | | | 22c. DEGREE
MD | | 22d. DATES SIGNED
1/29/81 | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald | | | | | | 23b. ADDRESS
8218 Wisconsin Ave., Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Sons, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 | | 25b. REGISTRAR'S SIGNATURE
Fitzgerald | | | |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | | | | | | | |



Washington, D.C.
Montgomery
Formed House Training Home
Washington, D.C.
Lower
Person
Washington, D.C.
Person

5130 Wisconsin Ave., N.W., Washington, D.C. 20016
Joseph D. Miller's Home, Inc.
Washington, D.C.
FEB 2 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02584 | |
|--|--|------------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} LeRoy ^{MIDDLE} B ^{LAST} Price | | | | | | | | | | 2a. DATE KNOWN OF DEATH ^{MONTH} Jan ^{DAY} 17 ^{YEAR} 1981 ^{HOUR} 12 ^{MIN} 00 | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH ^{MONTH} Feb ^{DAY} 20 ^{YEAR} 60 | | 6. AGE (IN YEARS) 60 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Tak Park | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Advent. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Military | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY Mont | | 13c. CITY OR TOWN D.C. Spg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8600 16th. Street, | | | |
| 14. FATHER'S NAME ^{FIRST} Hosea ^{MIDDLE} ^{LAST} Price | | | | 15. MOTHER'S MAIDEN NAME ^{FIRST} Amy ^{MIDDLE} ^{LAST} Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 24 yrs. | | 17. INFORMANT (wife) Gertrude M. Price-(same as 13e) | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Rogers</i> | | | | TITLE (SPECIFY) M.D. <i>beg</i> | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME | | | | ADDRESS Silver Spring, Maryland | | | | DATE SIGNED Jan 17, 1981 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-22-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | | | | 25b. REGISTRAR'S SIGNATURE <i>Clark E. Wilson</i> | | | |
| 8434 Ga. Ave., S.S. Md. | | | | | | | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

1

0

2

5

8

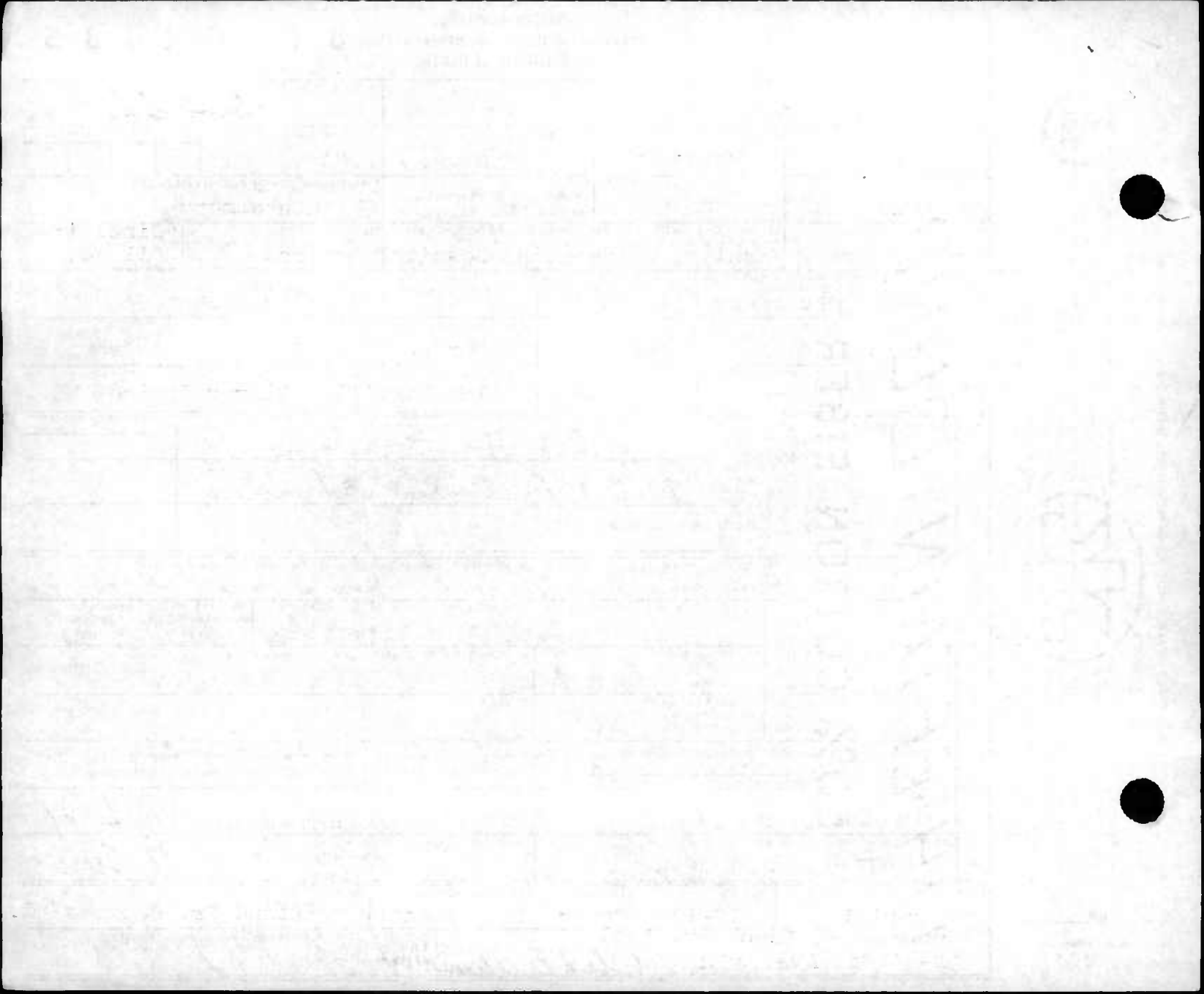
5

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) RALPH F PRICE | | | 2a. DATE OF DEATH
MONTH 1 DAY 14 YEAR 1981 2b. HOUR 1:41 P.M. | |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH 12 DAY 28 YEAR 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Bil. Spring | | | 12b. Singular OR INDUSTRY
Oil Co. | |
| 14. FATHER'S NAME
FIRST Clifford MIDDLE E. LAST Price | | 15. MOTHER'S MAIDEN NAME
FIRST Gertrude MIDDLE J. LAST Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 677-10-0016 | | 17. INFORMANT
(niece) 8315 First Ave., Silver Spring, Md. |

| | | | | |
|--|--|--|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Recent Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic obstructive lung disease
Reveal failure, Septicemia | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/24 , 19 80 , to 1/14 , 19 81 , that (I) (we) last saw the deceased alive on 1/14 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Antonio G. Uy | | DEGREE
MD | 22c. DATE SIGNED
1/14/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Antonio G. Uy | | 22e. ADDRESS
831 Hill Blvd E Silver Spring Md 20903 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
1-17-1981 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Georges Md. | |
| 24. FUNERAL DIRECTOR
NAME Warner E. Pumphrey, Inc.
ADDRESS 8434 Ga. Ave., S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 25b. REGISTRAR'S SIGNATURE [Signature] | | |



Item 6 g553 3/10/81 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02586

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Hom Suey Oy Quinn (Also known as Suey Oy Hom Yee) | | | | | | | | Jan 26 1981 | | | | | | | | 7:00 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| F | Y | Oct. 9, 1917 | | 64 YRS. | | | | | | Jan 26, 1981 | | | | | | 5:30 P.M. | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Canton, China | | United States | | | | | | Montgomery MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| S. I. Spg | | 13101 Metex Rd | | Cook | | Buddha | | Restaurant | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | |
| MD | | Mont. S. I. Spg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13101 Metex Rd | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Unknown | | Hom | | Unknown | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 578-54-4696 | | Dickey Yee (son) | | 12701-Ruxton Rd. Silver | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 4029 | | | | Acute Myocardial Dis | | | | | | | | | | | | | |
| | | | | (b) Hypertensive Heart Dis | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | | | | | | | |
| John S. Rogers, MD | | Silver Spring, Maryland | | | | Jan. 26 1981 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 1-30-1981 | | Arlington National Cem. | | Arlington, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| J. Wm. Lee's Sons Co. | | 300-4th St., NE, Wash., D.C. | | JAN 29 1981 | | [Signature] | | | | | | | | | | | |

(Yes)

London, Ontario, Canada

400

no. 012, J

DATE: _____

Indonesian, 1970-1971

1997, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1997

1. The following information is for your information only.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 8 7

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE VIOLA LAST QUINN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01-05-81 | | 2b. HOUR
10 ³⁷ A.M. | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 30, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10500 ROCKVILLE PIKE, 20852 | | | |
| 14. FATHER'S NAME
FIRST EDWARD MIDDLE R. LAST BARBOUR | | | | 15. MOTHER'S MAIDEN NAME
FIRST MARY MIDDLE A. LAST DOWNING | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
262-43-2487 | | 17. INFORMANT
DOROTHY V. QUINN DAUGHTER | | | | SAME AS 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4140 CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE (rev. 4/85)
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Hour | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
DIABETES MELLITUS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-30, 1981, to 1-5, 1981, that (I) (we) lost
saw the deceased alive on 1-5, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Richard H. Pollen | | | | DEGREE
MD | | | | 22c. DATE SIGNED
1-5-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD H. POLLEN, M.D. | | | | 22e. ADDRESS
10,400 Connecticut Avenue Kensington, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON, D. C. | | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "At Work" checkboxes any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 5 8 8 | | | |
|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ANNA MARIE RACEK | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 25, 1981 | | 2b. HOUR
1015 M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH MONTH DAY YEAR
DEC. 10 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
91 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORWAY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NNMC National Naval Medical | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
MD | | 13b. COUNTY
MONT | | 13c. CITY OR TOWN
POTOMAC | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
OLE - HALVERSEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MAREN HELENE JOHANSEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
516-60-9419 | | 17. INFORMANT ADDRESS
MRS MAGUERITE BARCHET TERR. 20854 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OSTEOPOROSIS AND MULTIPLE MYELOMA
7330
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that this hospital attended the deceased from JAN. 10, 19 81 to JAN. 25, 19 81 , that we lost saw the deceased alive on JAN. 25, 19 81 , and that in our opinion death occurred on the date and hour and from the causes stated above, we do not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Roy S. Small | | | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
25 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Roy S. Small | | | | 22e. ADDRESS
National Naval Medical Center Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Jan/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland, P.G. Co., Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Chambers Funeral Home Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 | | 25b. REGISTRAR'S SIGNATURE
Jeffrey McCreedy | |

MEDICAL CERTIFICATION

29

1

10

6000 BP

00000

001 00 000 00

001 00 000 00

001 00 000 00

001

001 00 000 00

001

001 00 000 00

001

001 00 000 00

001 00 000 00

001 00 000 00

001 00 000 00

001 00 000 00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102589

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE (NMN) RADIN | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 4 81 | | 2b. HOUR
7:30 P.M. |
| 3. SEX
MALE | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
1 29 95 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Yugoslavia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
COLONIAL VILLA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LAWYER | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
D.C. | | 13b. COUNTY
Washington | 13c. CITY OR TOWN
Washington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3223 KLINGLER RD NW |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dobrovoy Radin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Persida Perin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | 17. INFORMANT
Washington, D.C. 20008
Vida R. Stringer-daughter 3223 Klingler Rd. N.W. | | | |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) **Pneumonitis**
4370
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cerebrovascular accident hemiplegia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Cerebral arteriosclerosis**

5 days

4 yrs

10 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Malnutrition and dehydration

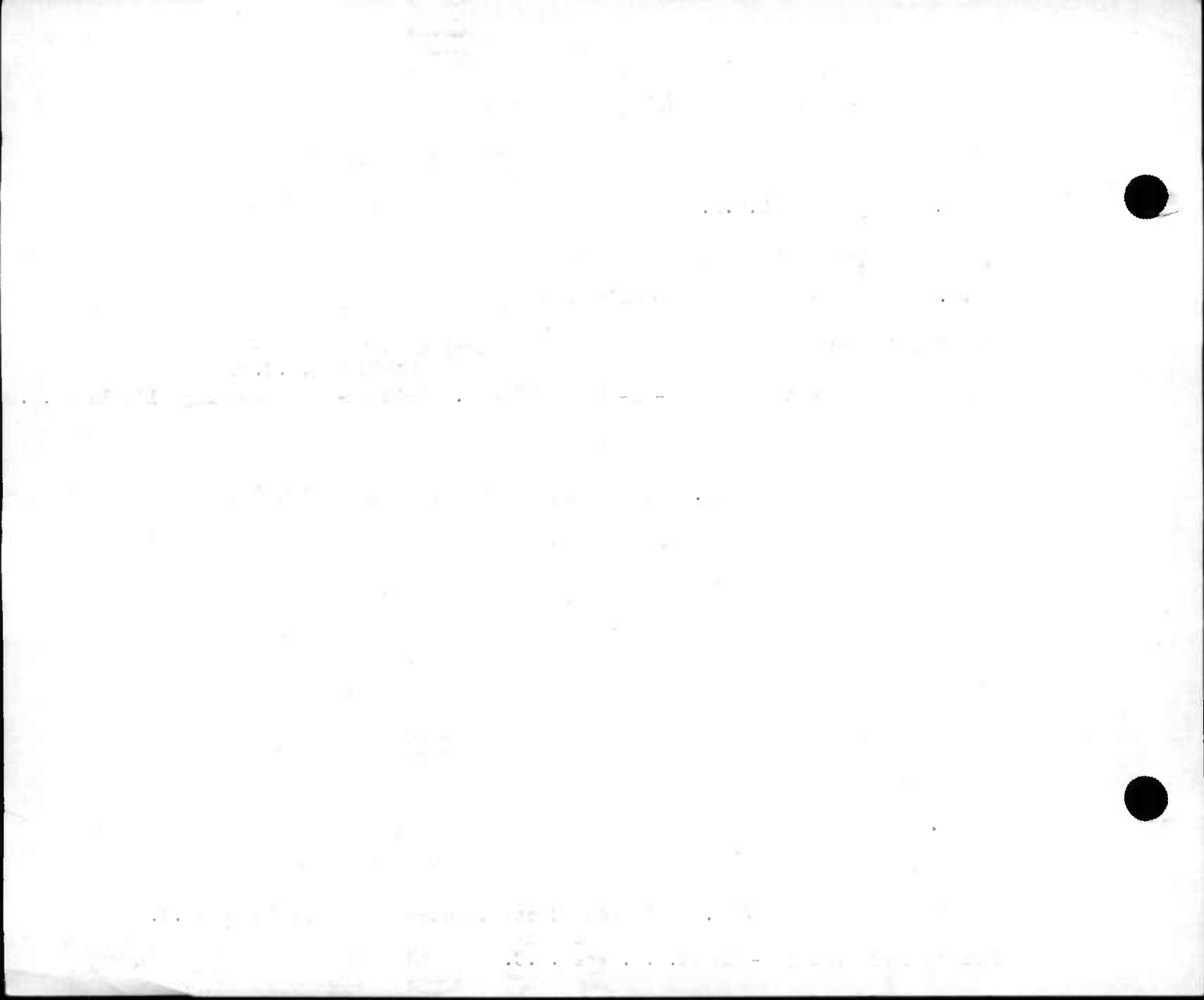
| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/18 , 19 77 , to 1/4 , 19 81 , that (1) (we) lost
saw the deceased alive on 12/26 , 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
George S. Kenton, MD | | DEGREE
MD | 22c. DATE SIGNED
1/5/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE S. KENTON | | 22e. ADDRESS
10620 Georgia Ave, S.S. Md. | |

| | | | |
|---|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6 Jan. 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Lee Funeral Home 300-4th St. N.E. Wash. D.C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | 25b. REGISTRAR'S SIGNATURE
Harry M. Brady |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 1 0 2 5 9 0

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|--|---|---|---|--|-----------------------------------|---|
| 1. DECEASED NAME
[TYPE OR PRINT] | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | |
| Richard W. Reed | | | 1 | 17 | 81 | 10:20AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE [IN YEARS LAST BIRTHDAY] | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | White | MONTH DAY YEAR
1 31 1894 | 86 | | IF UNDER 24 HRS
HOURS MIN | |
| 7b. BIRTHPLACE [STATE OR FOREIGN COUNTRY] | 7c. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | U S A | | | Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | 9110 Wire Ave. | | Engineer | | Structural | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9110 Wire Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | |
| Richard MJ Reed | | | Florence H Daland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| yes | | | 1917-1919 023 05 7501 | | Judson D. Reed (same as #13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | <i>2 months</i> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Genitourinary Neoplasia</i> | | | | | | <i>9 years</i> |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of Prostate</i> | | | | | | <i>4 years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<i>Hypertension and Congestive Heart Failure</i> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 15, 1980</i> to <i>Jan 17, 1981</i> , that (I) (we) lost
saw the deceased alive on <i>Jan 9, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Stephen Hulburt, MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Jan. 17, 1981</i> |
| 22d. PHYSICIAN'S NAME [TYPE OR PRINT] | | | | 22e. ADDRESS | | |
| R. Stevens Hulburt M.D. | | | | 3000 Dent Pl. N. W. Washington D.C. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Cremation | | 1-18-81 | | Metropolitan | | Alexandria Va. |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey Inc. | | | | 25a. DATE OF REGISTRATION
JAN 23 1981 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 14, 16b g551 1/23/81 gJ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02591

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward H. Reeves | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 4 81 | | 2b. HOUR
7:50 AM |
| 3 SEX
M | 4 RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
2 09 88 | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Texas | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Welfare of Conn., |
| 13a. STATE
Conn. | | 13b. CITY OR TOWN
New Haven | 13c. CITY OR TOWN
Madison | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Leonidas O. Reeves | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Tennessee Harwood | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 1 44-32-1348 | | 17 INFORMANT (wife) ADDRESS
Nell W. Reeves-(same as 13e) | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular ACCIDENT</u>
4360
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days |
|--|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from <u>December 29, 1980</u> to <u>January 4, 1981</u> , that (I) was last saw the deceased alive on <u>January 3, 1980</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) will (did) not view the body after death. | | | |
| 22b. SIGNATURE
<u>Barry Hecht</u> | | 22c. DATE SIGNED
JANUARY 4, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY HECHT | | 22e. ADDRESS
10620 GEORGIA AVENUE SILVER SPRING, MD 20906 | |

| | | | |
|--|-----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
1-4-1981 | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alex, MARYLAND VIRGINIA |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 25a. DATE RECEIVED BY REGISTRAR
JAN 8 1981 | |
| 24b. ADDRESS
8434 Ga. Ave., S.S. Md. | | 25b. REGISTRAR'S SIGNATURE | |

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02592

| | | | | | | | |
|--|--|---|--|---|--------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Mary V. Rice</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>JAN. 2, 1981</i> | | 2b. HOUR
<i>8:45A</i> | | |
| 3. SEX
<i>female</i> | | 4. RACE
<i>caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>April 17, 1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HRS. MIN.
<i>86</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Baltimore, Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County, MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>National Lutheran Home for the Aged</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Clerk</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>telephone or.</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Frank Dedral</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Barbara Kaplan</i> | | 13e. STREET ADDRESS
<i>14346 Parkside Drive</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>217-03-8700</i> | | 17. INFORMANT
ADDRESS
<i>Rev. Richard Reichard 9701 Veirs Dr. Rockville Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>
<i>4140</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Congestive Heart Failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) <i>Atherosclerotic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>JAN 27, 1977</i> to <i>JAN 2, 1981</i> , that (we) last saw the deceased alive on <i>JAN 2, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Elliott Aleskow</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-2-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Elliott Aleskow, M.D.</i> | | | | 22e. ADDRESS
<i>2141 K. St. NW Washington, DC</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Jan. 6, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Garden of Faith Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>The Hysong Company</i> | | | | ADDRESS
<i>1300 N St. N.W. Wash. D.C.</i> | | | |
| 25. REGISTRAR'S SIGNATURE
<i>IAN 14 1981</i> | | | | 25b. REGISTRAR'S SIGNATURE | | | |

171

172

173

x

...

...

174

175

176

177

Handwritten signature

178

179

180

...

...

...

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 9 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Margaret Kathleen RIEDEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Jan. 7, 1981 | | 2b. HOUR
6:00 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 30, 1910 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
70 | | |
| 10. CITY OR TOWN OF DEATH
Clarksburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
25001 Burnt Hill Road | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Clarksburg | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry F. Welsh | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Grace Kiplinger | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-54-7578 | | 17. INFORMANT
ADDRESS
Edgar J. Riedel Item 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ventricular fibrillation
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/21/76 , 19____, to 10/15/80 , 19____, that (we) lost now the deceased above (I/we) did not view the body after death. 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | |
| 22b. SIGNATURE
Pasqual Perrino
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/07/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Pasqual N. Perrino, M.D. | | | | 22e. ADDRESS
15 E. Deer Park Dr., Gaithersburg, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Maryland | | 23e. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | |

Olin E. Wainwright, P.A., Wainwright, N.J. 07081
 British 141001 Cedar Hill Switzerland
 Barnard V. Perrino, M.D. 15 E. Deer Park Dr., Fairport, N.Y. 140781

No 213-54-7578 Edgar J. Riedel Item 13
 Henry F. Welsh Parish Grace Ridgely

Maryland Mont. Clearwater xx 25001 Burnt Hill Road
 Clearwater 25001 Burnt Hill Road Housewife

Washington, DC USA Monticello
 White April 30, 1910 x

Jan. 7, 1981 8:00 A

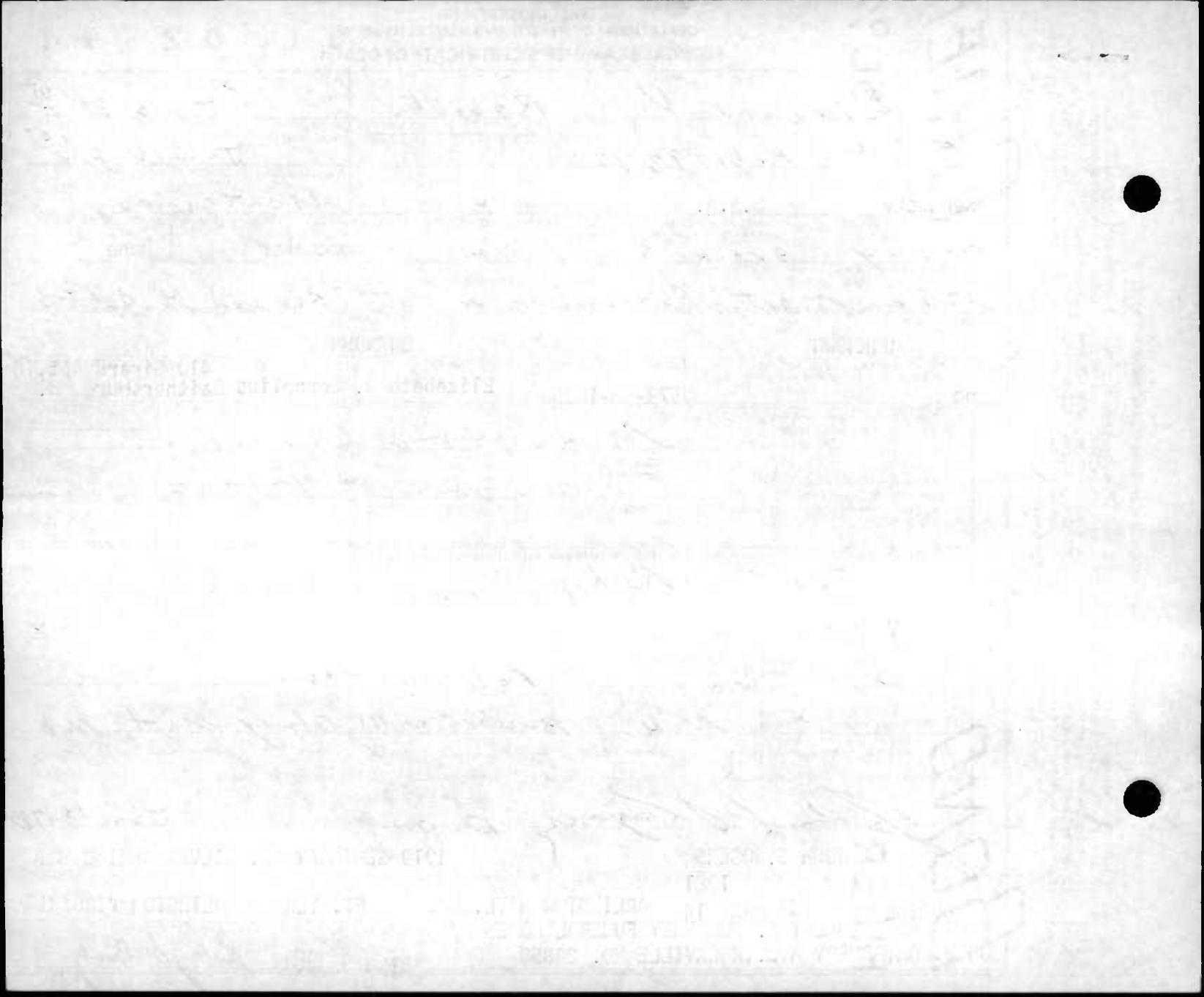
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **02594**

| | | | | | |
|---|---------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELEANOR V. Roberts | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Jan 10 1981 | | 2b. HOUR
10:15 | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 12 1929 | 6. AGE (IN YEARS)
LAST BIRTHDAY
52 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 11. KIND OF BUSINESS OR INDUSTRY
None | |
| 12. CITY OR TOWN OF DEATH
Olney | | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Brooks Grove N.H. | | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Mont. Gaithersburg | |
| 15. STATE
MD | | 16. CITY OR TOWN
Gaithersburg | | 17. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 18. STREET ADDRESS
410 Girard St. Apt. F3 | | 19. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 20. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 21b. SOCIAL SECURITY NO.
579-58-1805 | | 21c. INFORMANT
ADDRESS 410 Girard Apt. T3
Elizabeth R. Cornelius Gaithersburg, Md. | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of Rectum
DUE TO, OR AS A CONSEQUENCE OF
(c) Fracture of Hip | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 23a. DATE OF OPERATION
None | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fracture of Hip | | 24. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 25a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
1320 P.M. 1/11/81 Fall in room | | 25b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
1320 P.M. 1/11/81 | | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Fall in room | |
| 26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
N.H. | | 26c. LOCATION
STREET CITY OR TOWN COUNTY STATE
Brooks Grove Rd. Olney Mont. MD | |
| 27a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| 28. ACTUAL SIGNATURE
John S. Rogers | | 29. TITLE (SPECIFY)
M.D. Dupi | | 30. MEDICAL EXAMINER
DATE SIGNED Jan 16/81 | |
| 31. EXAMINER'S NAME
(TYPE OR PRINT)
JOHN S. ROGERS | | 32. ADDRESS
1919 SEMINARY RD., SILVER SPRING, MD. | | | |
| 33a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 33b. DATE
1981 JANUARY 14 | | 33c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATL. CEM. | |
| 33d. LOCATION
CITY OR TOWN COUNTY STATE
FT. MYER ARLINGTON VIRGINIA | | 34. DATE REC'D. BY REGISTRAR
JAN 19 1981 | | 35. REGISTRAR'S SIGNATURE
Hefsey/Kelley | |
| 36. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES P/A 300 W. MONTGOMERY AVE., ROCKVILLE, MD. 20850 | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

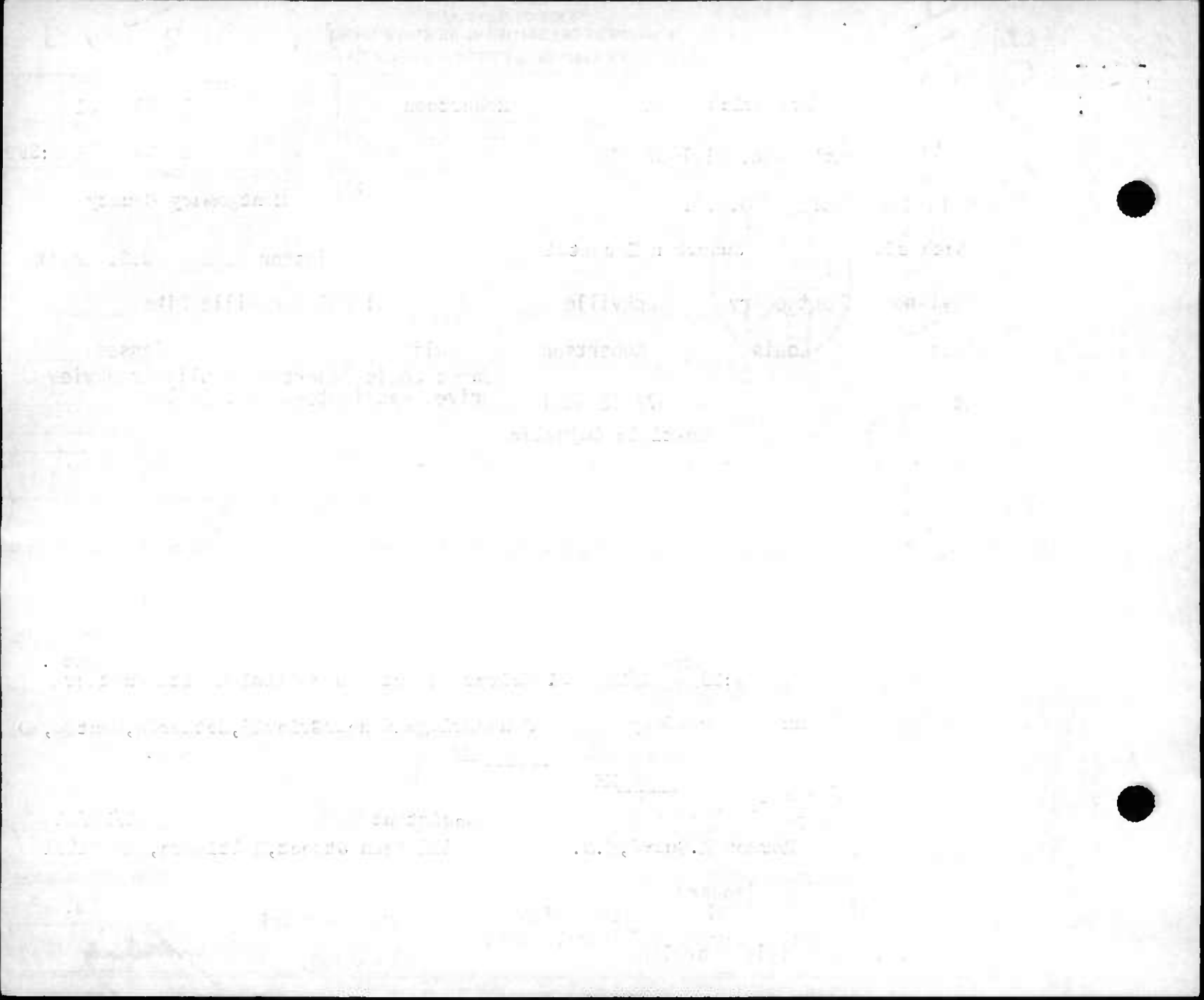
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02595 | |
|--|-------------------------|--|---|---|--|---|---|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Frederick Y. Robertson | | | | | | 2b. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 20 19 81 | | 2d. HOUR M | | | |
| 3. SEX
male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR Dec. 31, 1937 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 43 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1 20 19 81 | | 2d. HOUR 6:39 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Adjustor | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10232 Rockville Pike | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Louis Robertson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Jensen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
579-52-3561 | | 17. INFORMANT ADDRESS
James Louis Robertson - 5114-Brookview Drive, Washington, D.C. 20016 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Multiple injuries | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 8120
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR 6:25 PM MONTH DAY YEAR 1/20 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
auto. driver of auto in collision with another | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
roadway | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Jones Bridge Rd near Grier Rd, Bethesda, Mont Co, MD | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Hormez R. Guard</i> | | | | TITLE (SPECIFY)
Assistant | | MEDICAL EXAMINER | | DATE SIGNED
1/21/81 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Hormez R. Guard, M.D. | | | | ADDRESS
111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
January 23, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Va. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Humphrey | | | | ADDRESS
P.A., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Robert A. Humphrey</i> | | | |



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02596

| | | | | | | | | | |
|---|------------------|--|--|--|------------------|--|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William Robertson | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Jan 14 1981 | | | | 2b. HOUR 1233 | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH
MONTH DAY YEAR Jan 1 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD Jan 14 1981 | 2d. HOUR 1233 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont General Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Silverspr | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST James | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 068-05-3693 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
4291
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Chronic Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE John P. Rogers | | TITLE (SPECIFY) M.D. Dep. | | MEDICAL EXAMINER | | | DATE SIGNED Jan 14, 1981 | | |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME Anatomy Board ADDRESS Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | | | |

3205 BP

12

U.S.

NEW YORK

Telex No.

100-20-100

100-20-100

100-20-100

100-20-100

100-20-100

100-20-100

100-20-100

100-20-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 81 02597 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mildred E. Robins | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-7-81 | | 2b. HOUR
2 AM | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-7-01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dirk - Tike | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sina - Brunswick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
Isabelle Schrider | | ADDRESS
12209 Greenridge Dr.
Boys, Md. 20720 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
2030
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Multiple Myeloma</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 min
24 hrs
3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>76</u> , to <u>Jan 6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>James R. Moore Jr.</u> | | DEGREE
MD | | 22c. DATE SIGNED
1-7-81 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. | | 22e. ADDRESS
207 Brookes Ave Gaithersburg Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 9, '81 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. Cemetery | | 23d. LOCATION
CITY OR TOWN STATE
Arlington Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Gartner Sandison F. H. | | 24b. ADDRESS
216 E. Diamond Ave.
Gaithersburg, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>History Halberg</u> | |

170X 200

graduate class

УДК 62-50

105-01-2233

2000

• H. I. Robinson, *Memphis*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

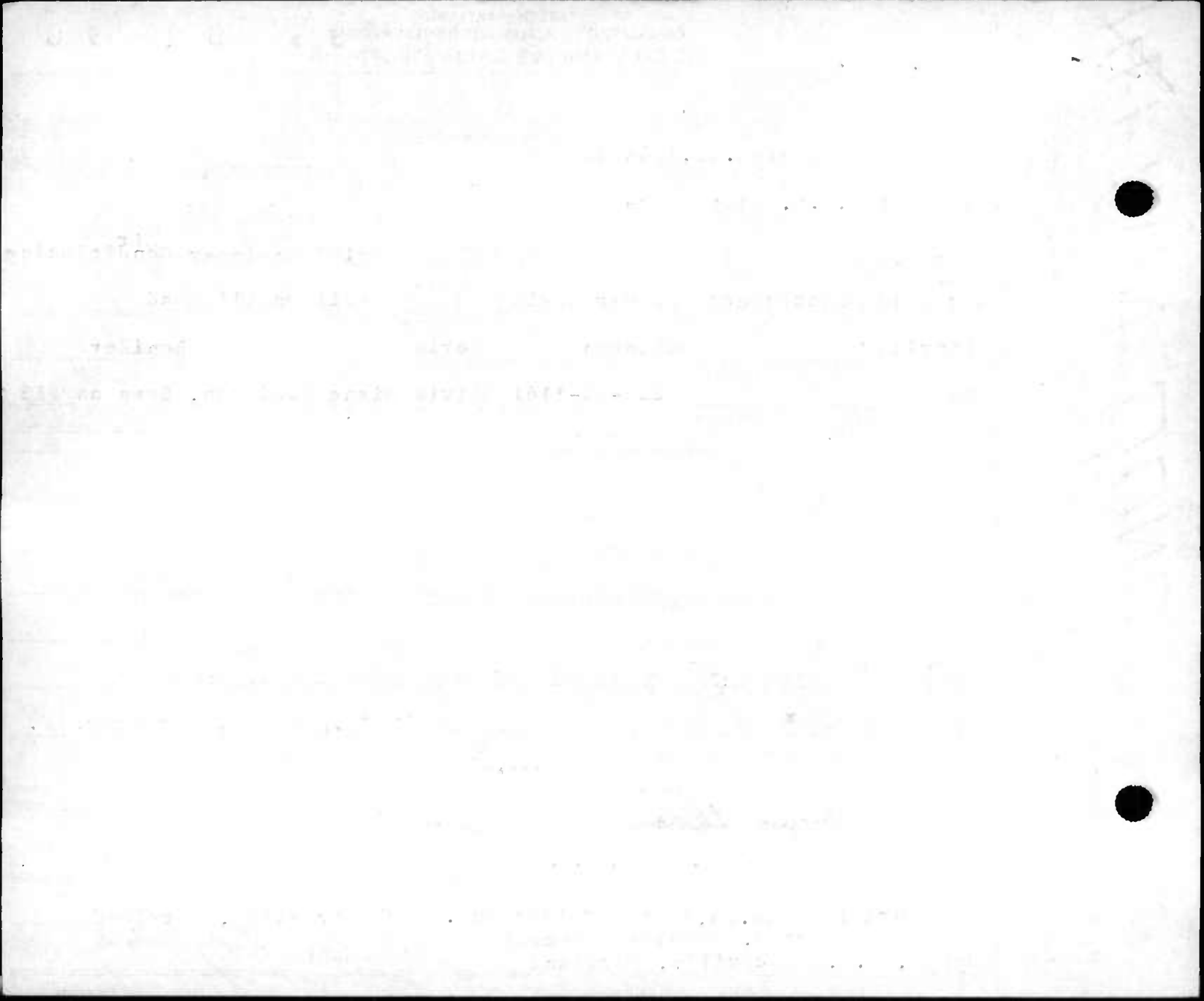
**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

02598

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|-------------------------------|--|--|--|----------------|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | <input checked="" type="checkbox"/> MONTH
<input type="checkbox"/> ESTI-
MATED | | DAY | | YEAR | | 2b. HOUR | |
| Charles C. Robinson | | | | | | | | 1 19 1981 | | | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | | MONTH DAY YEAR | | 2d. HOUR | | PM | |
| Male | White | Feb. 25, 1944 | | 36 | | | | | | 1 19 1981 | | | | | | 11:19 PM | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Washington, D.C. | | United States | | | | Montgomery County | | MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
INDUSTRY | | | | | | | | | | | |
| Olney | | Montgomery General Hospital | | Chief Engineer | | Conditioning | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Montgomery | | Silver Spring | | | | 4511 Dahill Road | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Charles Robinson | | Doris Honiker | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | |
| No | | 220-38-1141 | | Olivia Diane Robinson, Same as #13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chest Injuries</u>
8150
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR <u>10:25</u> MONTH <u>1</u> DAY <u>19</u> YEAR <u>1981</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Driver of truck/fixed object impact | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Muncaster Mill Rd., Derwood, Montgomery, Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
Assistant | | DATE
SIGNED 1/20/81 | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Virginia L. Dolan | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | Jan. 23, 1981 | | Parklawn Mem. | | Park Rockville, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Humphrey Funeral
Homes, P.A. Rockville, Maryland | | JAN 29 1981 | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 02599 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William L. Robinson | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/2/81 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 31, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dir. of Safety | | 12b. KIND OF BUSINESS OR INDUSTRY
Amer. Auto. Assn. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John A. Robinson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Moshier | | 13e. STREET ADDRESS
1235 Potomac Valley Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
159-07-2933A | | 17. INFORMANT
John W. Robinson, Rockville, Md. 20854 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT
4140
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) AS H D | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 WEEKS
YEARS
" | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/2/81 to 1/2/81 , that (1) (we) last saw the deceased alive on 1/2/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE
THOS G. WARD DEGREE MD | | | | 22c. DATE SIGNED
1/2/81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOS G. WARD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc.
5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | 25. DATE RECEIVED BY REGISTRAR
JAN 12 1981 | | 26. REGISTRAR'S SIGNATURE
Robert M. Brady | |

ROBINSON

WHITE

70

Oct. 31, 1904

White

White

W. A.

New York

111. of Safety

1855 Potomac Valley and

Montgomery

Maryland

Hoover

Alia

Robinson

A.

John

1100 Castlewood Court

150-1-1000 John A. Robinson, Rockville, Md. 20854

no

2100, Maryland

1100-1-1000

W. A.

John

1100-1-1000 John A. Robinson, Rockville, Md. 20854

1100-1-1000 John A. Robinson, Rockville, Md. 20854

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 81026000 | | |
|---|--|--|--|--|--|---|---|---|--|---|----------|--|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) MARGARIT M. RODENBURG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 5 '81 | | | 2b. HOUR 12 30 M | | | | |
| 3. SEX FEMALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH March 14 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home | | | | 12a. USUAL OCCUPATION Real Estate Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't | | | | |
| 13a. STATE Washington 13b. COUNTY Pierce 13c. CITY OR TOWN Tacoma | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2902 South 84th Street | | | | | |
| 14. FATHER'S NAME FIRST David MIDDLE McCulloch LAST McCulloch | | | | | 15. MOTHER'S MAIDEN NAME FIRST Bethia MIDDLE Frances LAST Waddell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN? No | | 16b. SOCIAL SECURITY NO. 327 24 8811 | | 17. INFORMANT Carol Lawton ADDRESS 814 Carter Road Rockville, Maryland | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
4360
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.
DUE TO, OR AS A CONSEQUENCE OF (c) SENILE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SENILE | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from MAR 1980 to 1/5 81 , that (1) (we) lost saw the deceased alive on 12/28 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Thomas E. Ward DEGREE M.D. | | | 22c. ADDRESS 6116 Robinwood Bethesda, MD | | | 22d. DATE SIGNED 1/5/81 | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. WARD | | | 22f. ADDRESS 6116 Robinwood Bethesda, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE Jan. 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY BUSINESS FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND | | | | | | 25a. DATE RECD. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE Bethia McCulloch | | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

[Extensive section of illegible text, appearing to be a detailed report or memorandum. The text is mostly mirrored bleed-through from the reverse side of the page.]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02601 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Irene Frances Rosen | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 1 DAY 10 YEAR 1981 | |
| 3. SEX female 4. RACE white 5. DATE OF BIRTH JULY 20, 1920 6. AGE (IN YEARS) 60 YRS. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | | | | | | | | | | 2b. HOUR 10:16 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 1 10 1981 2d. HOUR 10:16 M | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) ADMIN. SECRETARY | |
| 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T. | | | | | | | | | | | |
| 13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 8201 16th St. | | | | | | | | | | | |
| 14. FATHER'S NAME ABRAHAM ROSEN 15. MOTHER'S MAIDEN NAME ROSE REINER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 577-14-0852 17. INFORMANT MORTON A. ROSEN ADDRESS 7501 DEMOCRACY BLVD. #B113 BETHESDA, MARYLAND | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
9570 IMMEDIATE CAUSE (a) MULTIPLE TRAUMA.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF FALL FROM 7th FLOOR WINDOW
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 930 PM 1 10 1981 JUMPED FROM 7th FLOOR WINDOW | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK Home 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| 22b. TITLE (SPECIFY) Dept MEDICAL EXAMINER DATE SIGNED 11/10/81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle Jr. ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 1/13/1981 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN 23d. LOCATION CITY OR TOWN COUNTY FALLS CHURCH, VIRGINIA | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 25. JAN 16 1981 26. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | | |



1900

1 10 31

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102602

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Elizabeth</u> <u>Rosenberg</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>January 14 1981</u> | | 2b. HOUR
<u>420 P.M.</u> |
| 3. SEX
<u>Female</u> | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>8 25 12</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>68</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Washington, D.C.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County MD.</u> | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring, Md.</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<u>Md.</u> | | | 13b. COUNTY
<u>Montgomery</u> | 13c. CITY OR TOWN
<u>Silver Spring</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Harry</u> <u>Oxenbury</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Sophie</u> <u>Rubin</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>216-40-7282</u> | | 17. INFORMANT
ADDRESS
<u>David Rosenberg 414 E. Indian Spring Dr. Silver Spring, Md.</u> | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>19 DAYS</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
<u>4920</u> | | DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary Emphysema.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | |

| | |
|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Renal Failure, Cor Pulmonale, Chronic Brain Syndrome.</u> | |
|--|--|

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION
<u>12/30/80</u> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Respiratory Failure</u> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>1955</u> , 19 <u>81</u> , to <u>January 14 1981</u> , that (1) was lost
saw the deceased alive on <u>1/14</u> , 19 <u>81</u> , and that in (my) my opinion death occurred on the date and hour and from the causes stated
above, (1) my did not view the body after death. | | | |
| 22b. SIGNATURE
<u>Jack Crowell</u> | | 22c. DATE SIGNED
<u>January 14, 1981</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JACK CROWELL</u> | | 22e. ADDRESS
<u>2025 EYE ST. N.W. Washington DC 20006</u> | |

| | | | |
|---|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | 23b. DATE
<u>1-16-1981</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Nat'l. Mem. Park</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Falls Church, Virginia</u> |
| 24. FUNERAL DIRECTOR
NAME
<u>DANZANSKY GOLDBACK</u> | | 25a. DATE
<u>JAN 19 1981</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

22

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, with some lines underlined. A large 'X' is visible in the lower-middle portion of the page.]

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Body released by Dr. May 10:45 1-3-81
MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 02603 | |
|--|--|---|---|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Reubin Rosenberg | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 3 81 | | | 2b. HOUR
10:29P
M | | |
| 3. SEX
Male | | 4. RACE
Cauc | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 12 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GROCERY STORE | | 12b. KIND OF BUSINESS OR INDUSTRY
CROGER | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
12630 Veirs Mill Rd. Rockville, Md. 2085 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL - - - ROSENBERG | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(UNKNOWN) Sadie Susel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-48-4609 | | 17. INFORMANT ADDRESS
JACK SAGE (SON-IN-LAW) 13915 FLINTR. RD, ROCKVILLE MARYLAND | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease 5 years
DUE TO, OR AS A CONSEQUENCE OF (c) 4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 21g. I certify that (I) (this hospital) attended the deceased from 1/3/80 19 80 , to 4/5 19 81 , that (I) (we) last saw the deceased alive on 1/3/80 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
GARY FISHER | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22b. DATE SIGNED
1/3/81 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
GARY FISHER | | | | | | 22d. ADDRESS
5530 WISCONSIN AVE. CHEVY CHASE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
JAN. 5, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
JUDEAN MEMORIAL GARDENS | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OLNEY, MONTGOMERY, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

3501
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02604

| | | | | | | | | | | | | | | | |
|--|--|----------------------|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary P. Ross | | | | 2a. DATE KNOWN OF DEATH ESTIMATED Jan 9 1981 | | | | 2b. HOUR 3:15 | | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH
MONTH DAY YEAR April 5 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD Jan 9 1981 | | 7d. HOUR 3:15 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wm. V. Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSTESS | | | | 12b. KIND OF BUSINESS OR INDUSTRY TEMPLE UNIV. | | | |
| 13a. STATE MD | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN Silver Spring | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST JOSEPH PORTER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST CARRIE DOW | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 182-26-8423 | | | |
| 17. INFORMANT Niece | | | | ADDRESS JANET BROOKS, 9402 HUGHES CT., ADELPHI, MD. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
4029
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Hypertension and Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Yrs | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Fracture left hip | | | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 19a. DATE OF OPERATION Nov 20 1980 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture l. hip | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR 11 20 1980 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE Montgomery Ave Silver Spring Mont. MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers, M.D. | | | | TITLE (SPECIFY) Dep | | | | DATE SIGNED Jan 9 1981 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | ADDRESS 1919 Seminary Road Silver Spring | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | | 23b. DATE JAN. 10, 81 | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS | | | | ADDRESS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SERIAL: [Illegible]

FILE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

41. [Illegible]

42. [Illegible]

43. [Illegible]

44. [Illegible]

45. [Illegible]

46. [Illegible]

47. [Illegible]

48. [Illegible]

49. [Illegible]

50. [Illegible]

51. [Illegible]

52. [Illegible]

53. [Illegible]

54. [Illegible]

55. [Illegible]

56. [Illegible]

57. [Illegible]

58. [Illegible]

59. [Illegible]

60. [Illegible]

61. [Illegible]

62. [Illegible]

63. [Illegible]

64. [Illegible]

65. [Illegible]

66. [Illegible]

67. [Illegible]

68. [Illegible]

69. [Illegible]

70. [Illegible]

71. [Illegible]

72. [Illegible]

73. [Illegible]

74. [Illegible]

75. [Illegible]

76. [Illegible]

77. [Illegible]

78. [Illegible]

79. [Illegible]

80. [Illegible]

81. [Illegible]

82. [Illegible]

83. [Illegible]

84. [Illegible]

85. [Illegible]

86. [Illegible]

87. [Illegible]

88. [Illegible]

89. [Illegible]

90. [Illegible]

91. [Illegible]

92. [Illegible]

93. [Illegible]

94. [Illegible]

95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

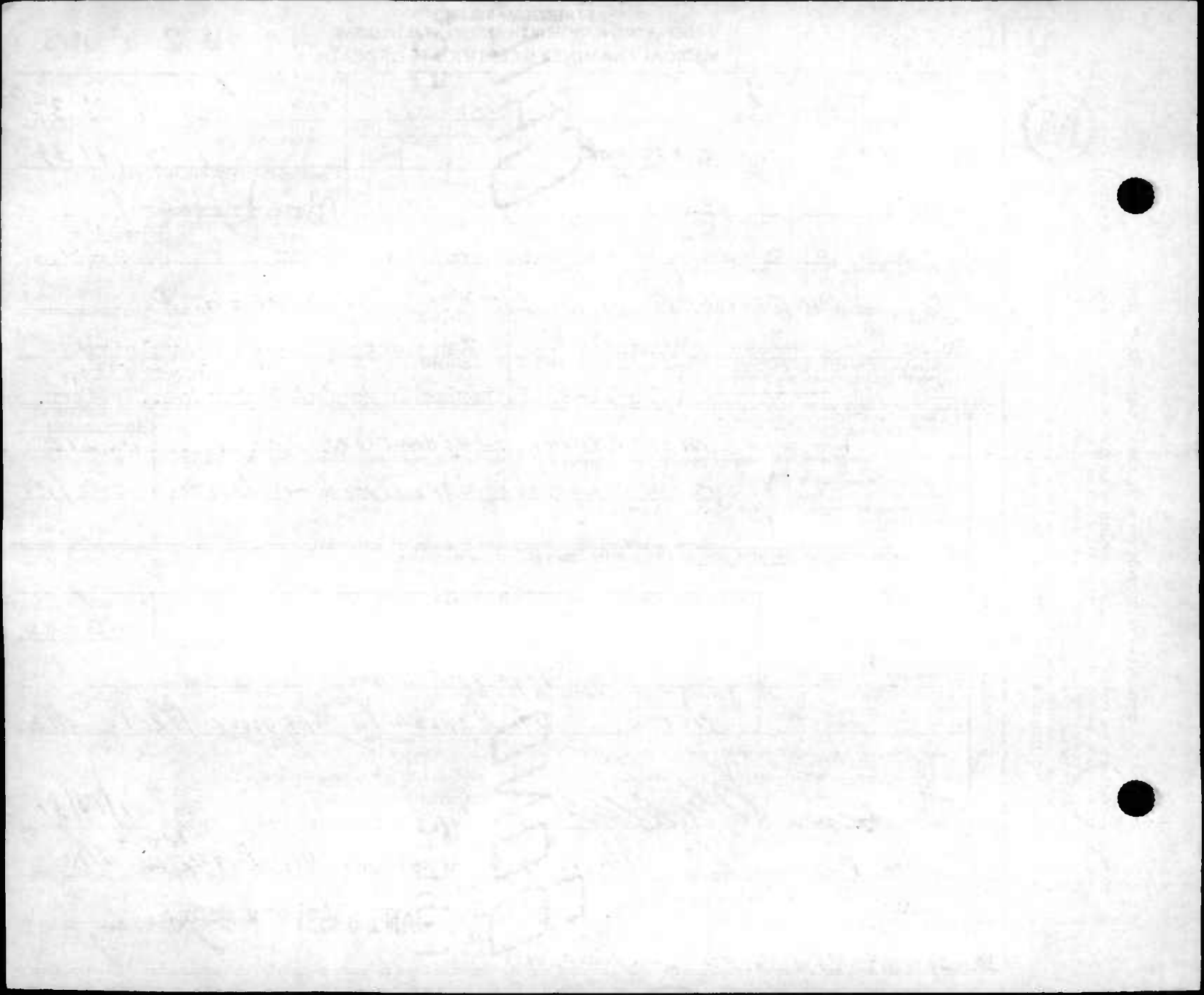
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02605

| | | | | | | | | | |
|--|-----------------|---|--|---|------------------|--|--|--|---------------------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Edward | MIDDLE | LAST
Rousseau | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 01 14 1981 | | 2b. HOUR
3:50 PM |
| 3. SEX
M | 4. RACE
CAUC | 5. DATE OF BIRTH
MONTH DAY YEAR Jan 12, 1985 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 96 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1 14 1981 | | 2d. HOUR
3:50 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adv. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS
Plumbing Supplies | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
Rockville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jules ----- Rousseau | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Henriette --- Auclair | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
N | | 16b. SOCIAL SECURITY NO.
036-28-9345 | | 17. INFORMANT
Jewett City, Conn.
Charles Gagne; 164 Slater Ave., Conn. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4100 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
2-3 yrs } DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FALL AT HOME | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
771 AZALEA DR ROCKVILLE MONT. MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
Francis C. Maylo | | TITLE (SPECIFY)
M.D. DEPT | | DATE SIGNED
1/14/81 | | MEDICAL EXAMINER
20014 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C. Maylo | | ADDRESS
8200 Wisconsin Ave Bethesda MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-17-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lisbon Conn. | | | |
| 24. FUNERAL DIRECTOR
NAME
DAN ZANSKY GOLDBERG F.H. | | ADDRESS
1170 ROCKVILLE PK ROCKVILLE, MD | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 81 02606 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
STEPHEN PAUL RUBACK | | | | January 12, 1981 | | | |
| 2. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 17, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
PRINTER | | 12b. BUSINESS OR PROFESSION
PRINTING OFFICE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
PRINCE GEO. | | 13c. CITY OR TOWN
COLLEGE PARK | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN RUBACK | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ROSTIE Tastucha | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
161 01 7607 | | 17. INFORMANT
8604 49th Avenue
William F. Ruback College Park, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
1579
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Myocardial infarction</u>
(c) <u>Cancer of pancreas</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
1 wk. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Contracture</u> | | | | | | | |
| 19a. DATE OF OPERATION
12/21/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Biliary Tract obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/81 to 1/12/81, that (I) (we) lost
saw the deceased on 1/12/81, and that (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/14/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. Eickler, M.D. | | | | 22e. ADDRESS
3915 Fenwick Dr. Wheaton, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Michael's Church Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansford Carbon Pa | |
| 24. FUNERAL HOME
Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

15

74

NOV 17, 1900

UNIT

24

...

NOV 17, 1900

24

NOV 17, 1900

NOV 17, 1900

24

NOV 17, 1900

NOV 17, 1900

NOV 17, 1900

24

NOV 17, 1900

NOV 17, 1900

24

NOV 17, 1900

NOV 17, 1900

NOV 17, 1900

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

5902

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8102607 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY | |
| Violet B. Russell | | | | | | | | | | January 21, 1981 | |
| 2. SEX | | | | | | | | | | 2b. HOUR | |
| Female | | | | | | | | | | 8:15 A | |
| 4. RACE | | | | | | | | | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| White | | | | | | | | | | April 12, 1905 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| England | | | | | | | | | | 7.5 | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| U.S.A. | | | | | | | | | | BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | | | | | | | | | Housewife | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Suburban Hospital | | | | | | | | | | Home | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | |
| Maryland | | | | | | | | | | Montgomery | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Bethesda | | | | | | | | | | 6313 Winston Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | |
| Robert Bruce | | | | | | | | | | Margaret Mc Cullough | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | |
| No | | | | | | | | | | 220-44-4349 | |
| 17. INFORMANT | | | | | | | | | | 3014 Burnleigh Rd. SW | |
| Wm. B. Russell | | | | | | | | | | Roanoke, Virginia | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) METASTATIC CARCINOMA | | | | | | | | | | 3-4 months | |
| 1659 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | |
| (b) LUNG CANCER - LARGE CELL | | | | | | | | | | 6-8 months | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | | | | | | | P.M. 19 | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1980, to 21 Jan 1981, that (we) lost the deceased alive on 21 Jan 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | |
| Eugene P. Libbe MD | | | | | | | | | | 21 Jan 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| EUGENE P. LIBBE MD | | | | | | | | | | 10500 CORN AVE KENSINGTON, MD 20745 | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 23b. NAME OF CEMETERY OR CREMATORY | |
| Burial | | | | | | | | | | Columbia Gardens | |
| 23c. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | 23d. DATE REC'D. BY REGISTRAR | |
| Arlington, Virginia | | | | | | | | | | JAN 29 1981 | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | | | | | [Signature] | |

1951

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

MEDICAL CERTIFICATION

| | | | |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
1/21/81 | 23c. NAME OF CEMETERY OR CREMATORY
St. Mark's C Church Cem | 23d. LOCATION CITY OR TOWN, COUNTY, STATE
Fairland, Maryland |
| 24. FUNERAL DIRECTOR NAME
Hines/Rinaldi F.H.11800 | | 25. REGISTRAR'S SIGNATURE
JAN 29 1981 | |

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 19 79</u> to <u>JAN 16 1981</u> , that (I) (we) lost saw the deceased alive on <u>JAN 16 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>G. L. Galt</u> DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/18/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. L. Galt | | | | 22e. ADDRESS
8630 FENTON St. Spg. Md. | |

| | | | | | |
|---|--------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Margarette B. Rydell | | 2a. DATE OF DEATH MONTH DAY YEAR
11/18/81 | | 2b. HOUR
7:24 P.M. | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH MONTH DAY YEAR
3/2/24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Sike Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, "T ADDRESS")
10619 Kinloch Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Isaac E. Brooks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ann Wilkinson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
579-20-9025 | | 17. INFORMANT ADDRESS
Paul Rydell (Husband) Same as above | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u>
<u>1830</u>
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Ovary</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>12 mos.</u>
<u>14 mos.</u> |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8102608

0002

100

100

100

100

100

100

100

100

100

100

100

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

100-100-etc

Cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02609

| | | | |
|--|--|---|---|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOAN Lee SANDERS | | 2a. DATE OF DEATH MONTH DAY YEAR
1/4/81
2b. HOUR
4 P M | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 9, 1942 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheltered Workshop | 12b. KIND OF BUSINESS OR INDUSTRY
n/a | | |
| 13a. STATE
W. Va. | 13b. COUNTY
W. Va. | 13c. CITY OR TOWN
Wardensville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley F. Sanders | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucille Wilson | 13e. STREET ADDRESS
Carpenters Ave. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | 16b. SOCIAL SECURITY NO.
212-64-6149 | 17. INFORMANT
ADDRESS
Lucille Sanders / Mother Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>CARDIAC ARREST</u>
<u>4100</u>
DUE TO, OR AS A CONSEQUENCE OF
(b). <u>Acute Myocardial Infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c).
DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10-12 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Crownary artery Disease</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from <u>1/4</u> , 19 <u>81</u> , to <u>1/4</u> , 19 <u>81</u> , that (1) (we) lost
saw the deceased alive on <u>1/4/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Alberto Rotstein</u> | | 22c. DATE SIGNED
1/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALBERTO ROTSTEIN | | 22e. ADDRESS
10401 Old Georgetown Rd Bethesda Md | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1981
Jan. 7 | 23c. NAME OF CEMETERY OR CREMATORY
Greenfield Cemetery | 23d. LOCATION
Wardensville, West Virginia |
| 24. FUNERAL DIRECTOR
NAME
Capitol Funeral Service, Fairfax, Va. | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1981
25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

SPARKS

1960

2500

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 81 02610 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Alejandro Jose Sandoval | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 1 81 | | 2b. HOUR
6:50 P.M. | |
| 3. SEX
MALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR
1 1 81 | | 6. AGE (IN YEARS LAST BIRTHDAY)
NEWBORN YRS MONTHS DAYS
2 5 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONT GOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
never employed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Virginia | | 13b. COUNTY
none | | 13c. CITY OR TOWN
Alexandria | | 13d. STREET ADDRESS
487 N. Armistead St. Apt 103 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Virgilio A Sandoval | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JEANNINE LARA | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no -- none | | | |
| 17. SOCIAL SECURITY NO.
none | | | | 18. INFORMANT ADDRESS
487 N ARMYSTEAD, ALEXANDRIA, VA 22312 | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7708 RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
John Van Brakle MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1-1-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN VAN BRAKLE | | | | 22e. ADDRESS
1500 FOREST GLEN, SILVER SPRING, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland | | | | 25a. DATE OF DEATH BY REGISTRATION
25b. REGISTRAR'S SIGNATURE | | | |

BP _____



Hospital

never employed
Alexandria, Va.

Virginia none Alexandria

487 N. Westend St. Apt 102

none

no

1951 Knoxville Tenn to Va. 1/2/51
1951 Alexandria Va to Va. 1/2/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102611

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| Arbutus R. Saunders | | Female | | White | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| July 10 1894 | | 86 YRS | | Conn | |
| 8. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| U.S.A. | | Montgomery MD | | Chevy Chase | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 5100 Westport Rd. | | Teacher | | Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | |
| Md | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5100 Westport Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| Unknown | | Unknown | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | |
| 577-16-7817 | | Frederick Wells, Exec. 12907 Crookston Lane, Rockville, Md. | | 3310 Alzheimer Disease | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 12/31/1980 to 1/3/1981, that (I) (we) lost saw the deceased alive on 1/2/1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE | |
| 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| 1/3/81 | | Jack Klesh M.D. | | 1145--19th St., N.W. Wash., D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | 1/16/81 | | Cedar Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. NAME OF FUNERAL DIRECTOR | | 23f. DATE OF DEATH BY REGISTRAR | |
| Suitland Md. | | Joseph Gawler's Sons Inc. | | JAN 12 1981 | |
| 23g. REGISTRAR'S SIGNATURE | | 23h. NAME | | 23i. ADDRESS | |
| [Signature] | | 5130 Wisc. Ave., N.W. Wash., D.C. | | [Address] | |

11-5-100 St. N.W., Wash., D.C.

2.2.1. *Redox*

Revised 10/1/79
Joseph J. Lonsdale Inc.
P.O. Box 100, Wash., D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02612

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2b. HOUR OF ESTI- MATED 01 11 1981 7 P.M. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph J. Savitsky | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 1 11 1981 7 P.M. | | | | | | | | | | | |
| 3. SEX M | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR 3 22 43 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv. Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor | | | | 12b. KIND OF BUSINESS OR INDUSTRY N.I.H. | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN GAITHERSBURG | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 15 MARQUIS DR. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Stanley Savitsky | | | | | | | | | | | | | | | | | | | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Dolores Pedlic | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. - 179-32-3782 | | | | 17. INFORMANT ADDRESS Ann Shirley Savitsky 15 Marquis Dr., Gaithersburg, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | |
| CHOPPING WOOD | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 11 1981 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 15 MARQUIS DR. GAITHERSBURG MONT MD | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Respiratory causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ARTIST'S SIGNATURE | | | | TITLE (SPECIFY) M.D. | | | | MEDICAL EXAMINER | | | | DATE SIGNED 4/11/81 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) F.C. MARYLE MD | | | | ADDRESS 800 Wisconsin Ave. Bethesda MD | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan. 15, '81 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Scranton Lackawanna Pa. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert Sandison | | | | 316 E. Diamond Ave. | | | | 25a. D. J. FOR BURIAL JAN 16 1981 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Gartner Sandison F.H. Gaithersburg, Md. | | | | | | | | | | | | | | | | | | | | | |

... ..
... ..

1256-1301-295

SECRET

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 1 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Helen Schaeble | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-21-81 | | | 2b. HOUR
MIN
2³⁰ PM | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 4 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.H. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | |
| 13a. STATE
MD. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles C Aldrich-Ames | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Morse Ingalls | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
n/a | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
289-34-743 A | | 17. INFORMANT
ADDRESS
Mrs. Helen Bender Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic CARCINOMA
1890
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Renal cell carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 25 1970 to JAN 21 1981 , that (I) (we) lost the deceased alive on JAN 19 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Hubert J. Alpert | | | | DEGREE
MD | | 22c. DATE SIGNED
JAN 21, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUBERT J. ALPERT, M.D. | | | | 22e. ADDRESS
8630 FENTON ST
SILVER SPRING, MD. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 23, | | 23c. NAME OF CEMETERY OR CREMATORY
Junior Order | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Preston Caroline Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Harvey Williamson - Federalsburg, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

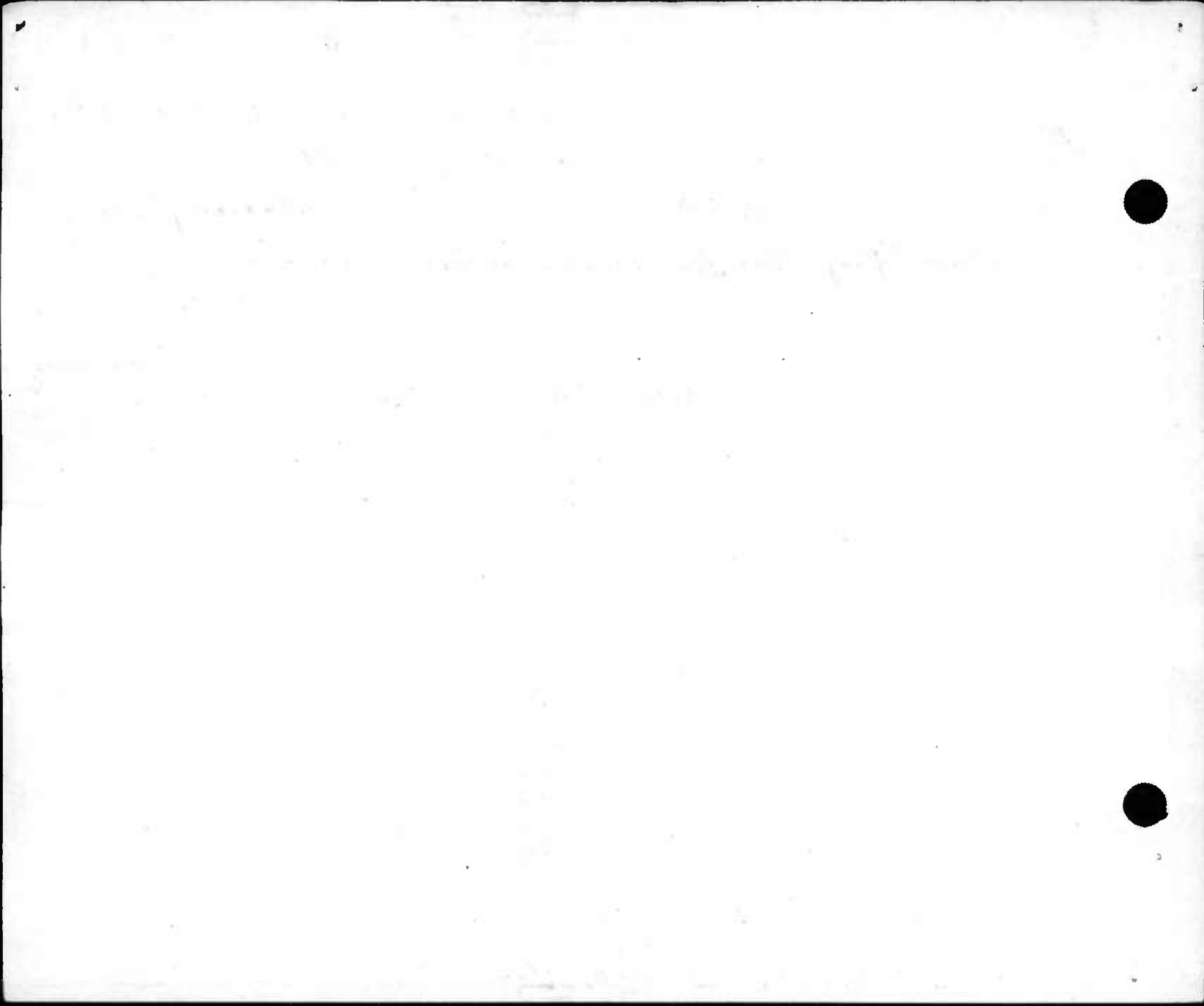


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 6 1 4 | | | |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) <i>Boo W Schekorra</i> | | | | 2a DATE OF DEATH MONTH DAY YEAR Jan. 1 29 81 | | 2b HOUR 1 45 AM | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Oct 10 18 26 | | 6 AGE (IN YEARS LAST BIRTHDAY) 54 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas City, Mo | | 7b CITIZEN OF WHAT COUNTRY? U.S.A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i> | |
| 10 CITY OR TOWN OF DEATH <i>Deloe Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bel Air Health Care Center</i> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. U. S. Navy | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Virginia | | | | 13b COUNTY Arlington | | 13c CITY OR TOWN | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Frederick William Schekorra | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Rumbke | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b SOCIAL SECURITY NO 500-22-1749 | | 17 INFORMANT ADDRESS Jefferson City Mo
Dr. Fred Schekorra 1100 Dogwood Dr., | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic carcinoma of lung</i>
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <i>carcinoma of lung</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs
3 yrs | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/28 19 89 to 1/29 19 81, that (I) (we) last saw the deceased alive on 1/28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <i>R.T. Benack MD</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED 1/29/81 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) R.T. Benack MD | | | | 22e ADDRESS 4115 Colie Dr Wheaton | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b DATE 1-29-81 | | 23c NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Kansas City, Mo | |
| 24 FUNERAL DIRECTOR <i>Charles F. H. Crutchfield, Jr., Alexandria, Va</i> | | | | 25a DATE REC'D. BY REGISTRAR FEB 6 1981 | | 25b REGISTRAR'S SIGNATURE <i>Robert M. ...</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR 15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02615

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|---|------------------------------------|--|--|--|--|--|--------------------------------------|--|----------|--|--|--|--|--|
| FOR
1- STATE REGISTRAR | | | | | | | | | | REG. NO. 02615 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | |
| FIRST MIDDLE LAST
Elisabeth M. Schwarzmnn | | | | | | | | | | MONTH DAY YEAR
1.16.1981 | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY | | IF UNDER 1 YR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2b. HOUR | | | | | |
| F | | W | | May 19 18 | | 62 YRS. | | MONTHS DAYS | | HOURS MIN | | 1.16.1981 | | 8:12 P | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Germany | | | | U.S.A. | | | | | | | | Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | | | Suburban Hospital | | | | Homemaker | | | | Home | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | | | | | | | | |
| Ohio | | | | | | | | | | Akron | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| Hugo Mengelkamp | | | | | | | | | | Not available | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| No | | | | | | | | | | 299-40-4684 | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | |
| Gabriele von Nordheim | | | | | | | | | | 7028 Buxton Terr., Bethesda, Md. 20034 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) <u>Hyper tensive Heart Dis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | None | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | | | | | | | TITLE (SPECIFY)
M.D. <i>Rep</i> MEDICAL EXAMINER | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) JOHN S. ROGERS | | | | | | | | | | ADDRESS
1919 Seminary Rd., Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| Cremation | | | | | | | | | | January 18 1981 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Metropolitan Crematory | | | | | | | | | | Alexandria Fairfax Virginia | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes P/A | | | | | | | | | | JAN 21 1981 | | | | | | | | | |
| 300 W. Montgomery Ave., Rockville, Md. 20850 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Hilary McCreedy</i> | | | | | | | | | |

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

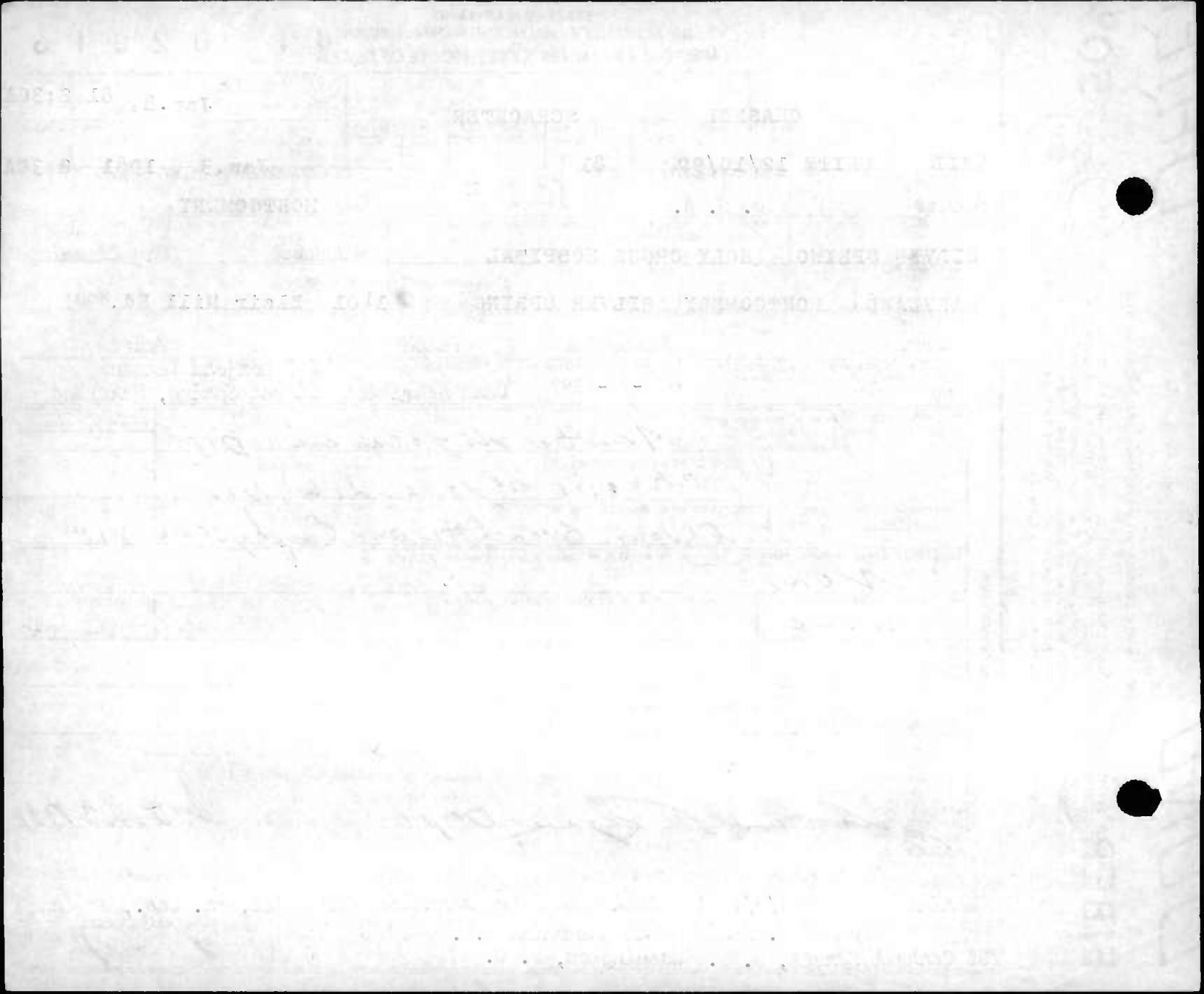
5. The fifth part of the report is a summary of the study. It includes a brief overview of the main points of the report and a final statement about the importance of the research.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

7. The seventh part of the report is an appendix. It includes any additional information that is relevant to the study, such as raw data, supplementary figures, or other supporting materials.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 0 2 6 1 6 | | |
|--|------------------|---|--|--|--|---|--|---|---|---|--|-------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CHASKEL SCHACHTER | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
Jan. 3, 1981 | | 2b. HOUR
2:30A |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
12/10/99 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
81 YRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | 2c. DATE PRONOUNCED DEAD
Jan. 2, 1981
2:30A | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Merchant | | 12b. KIND OF BUSINESS OR INDUSTRY
Dry Cleaning | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Blair Mill Rd. #901 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kalman Schachter | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Faiga Yekel | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-44-0599 | | 17. INFORMANT
857 Oxford Terrace
Carl Schachter Silver Spring, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
4912 IMMEDIATE CAUSE (a) Acute Myocardial Infarction
(b) Chronic Myocardial Infarction
(c) Chronic Bronchitis and Emphysema
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE
[Signature]
EXAMINER'S NAME (TYPE OR PRINT)
Donald M. Stein | | | | | | TITLE (SPECIFY)
M.D. Dep. | | MEDICAL EXAMINER | | DATE SIGNED
Jan 3 1981 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/5/1981 | | 23c. NAME OF CEMETERY
Cemetery
Bnai Israel Congregation | | | | 23d. LOCATION
CITY OR TOWN
Oxon Hill, Pr. Geo. Maryland | | 23e. DATE OF TRANSFER
JAN 9 1981 | | |
| 24. FUNERAL DIRECTOR
NAME
Donald M. Stein Hebrew Memorial F.H.
232 Carroll Street, N. W. Washington, D. C. | | | | | | 25a. DATE OF DEATH
JAN 3 1981 | | 25b. SIGNATURE OF FUNERAL DIRECTOR
[Signature] | | | | |



TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 1 7

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
SR.. Rosemarie Schubert | | | 2a DATE OF DEATH
MONTH DAY YEAR
1-7-81
4:25 PM | | |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5 DATE OF BIRTH
MONTH DAY YEAR
OCT 23 1896 | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | 7 UNDER 1 YEAR
MONTHS DAYS
UNDER 24 HRS
HOURS MIN. | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7c CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | 12b KIND OF BUSINESS OR INDUSTRY
RELIGIOUS ORDER | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN KENSINGTON | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
CHARLES JOSEPH SCHUBERT | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGUERITE MURPHY | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-72-3705 | 17 INFORMANT ADDRESS
SR. MAUREEN PATRICE SAME AS 13 SUPERIOR | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4340 Cardio-respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15
4 hrs.
5 yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Coronary Thrombosis, cardiac arrhythmias, HTN, Upper GI | | | | | |
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/3/78, to 1/7/81, that (I) (we) last saw the deceased alive on 1/6/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23a SIGNATURE
<i>Stephen N. Jones</i> | | DEGREE | | 23c. DATE SIGNED
1/7/81 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN N. JONES | | 23d. ADDRESS
809 VIERS MILL RD., ROCKVILLE, MD. | | | |
| 24a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 24b. DATE
1/10/81 | 24c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | | 24d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON, D.C. | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Ray H. Hickey</i> | |

11851-18

Taylor

[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 1 0 2 6 1 8
REG. NO. | |
|---|------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MURRAY SCHWEITZER | | 2a. DATE OF DEATH MONTH DAY YEAR
January 28, 1981 | | 2b. HOUR
3:00a.m. | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH MONTH DAY YEAR
Dec. 14, 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Contract & Purch. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Harry Schweitzer | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Pauline Kranitz | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 120-12-9277 | | 17. INFORMANT ADDRESS
Sonya Schweitzer; 3911 Minden Rd., Wheaton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonitis of Unknown Etiology
DUE TO, OR AS A CONSEQUENCE OF (c)
4860
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
1/21/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Exploratory Thoracotomy | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 10, 1981 , to January 28, 1981 , that (I) (we) last saw the deceased alive on Jan. 27, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Paul W. Johnson | | DEGREE
M.D. | | 22c. DATE SIGNED
1-28-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL W. JOHNSON, M.D. | | 22e. ADDRESS
6111 Executive Blvd., Rockville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-30-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Memorial Gardens | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Chapels; | | ADDRESS
Rockville, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Olney, Montg., Maryland | |
| 25. DATE RECEIVED BY REGISTRAR
FEB 2 1981 | | REGISTRAR'S SIGNATURE | | | |



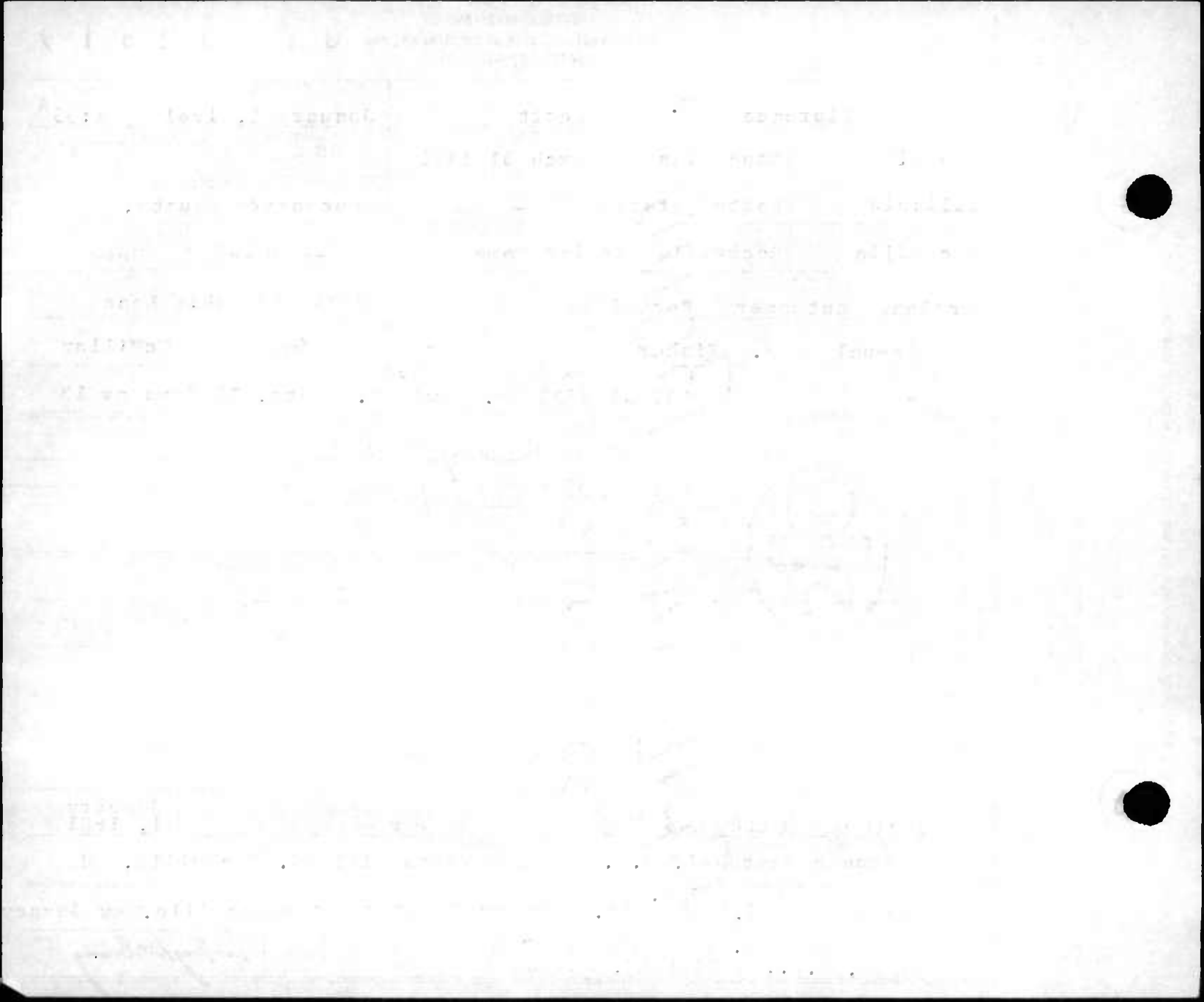
1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 1 9

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Florence F. Scott | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 1, 1981 | | 2b. HOUR
1:35 A |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
March 31 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rockville Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel J. Fisher | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Mary Ann McMillan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
137 54 8633 | | 17. INFORMANT
Son
ADDRESS
Dr. Lewis P. Scott, III Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardio-pulmonary arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) A.S.H.D., viral infection, CBS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-11 , 19 78 , to 1-1 , 19 81 , that (I) (we) lost
saw the deceased alive on 11-7 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Franke Westphal M.D. | | DEGREE | | 22c. DATE SIGNED
January 1, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Franke Westphal, M.D. | | 22e. ADDRESS
809 Veirs Mill Rd. Rockville, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Jan. 5, 1981 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pleasantville, New Jersey | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Robert A. Pumphrey</i> | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 6 2 0 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN SEBOL | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 5 81 | | 2b. HOUR 4:25 M | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 2, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROCUREMENT OFFICER, D.C. GOV'T | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. COUNTY MONTGOMERY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2113 COLERIDGE DRIVE, 20901 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH - - SEBOL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER - - LEVITZ | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-44-5304 | | 17. INFORMANT ADDRESS MILDRED SEBOL, COLERIDGE DR. SILVER SPR., MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
4100
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
13 HOURS
7 WEEKS
20 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 5 81 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 5 81 , to 11 5 81 , that (I) (we) last saw the deceased alive on 11 5 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE David Goldenberg MD DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/5/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID GOLDBERG MD | | | | 22e. ADDRESS SILVER SPRING, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN | | 23d. LOCATION CITY OR TOWN STATE FALLS CHURCH VIRGINIA | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. | | ADDRESS 117 ROCKVILLE MD | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and file within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

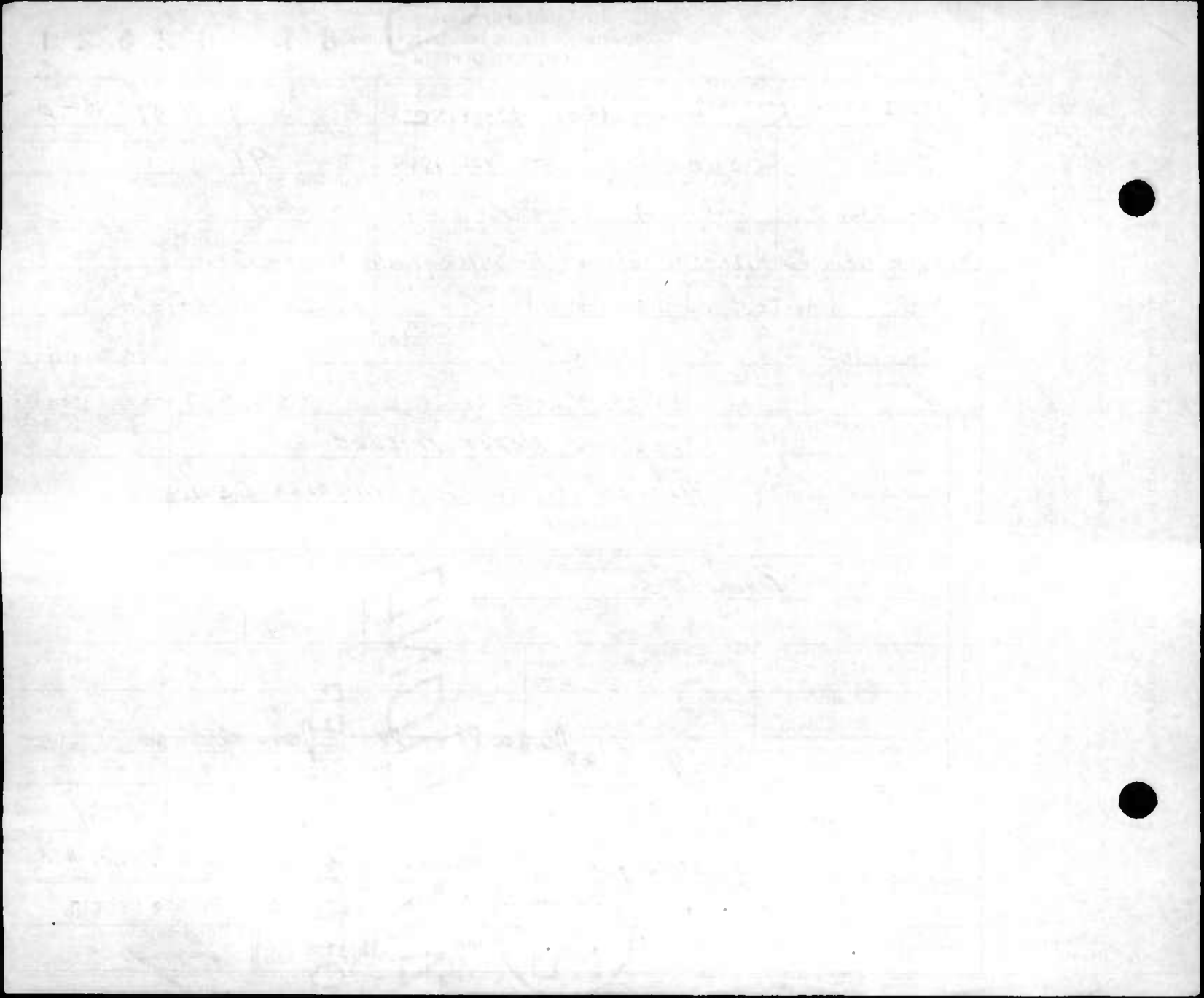
FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 6 2 1

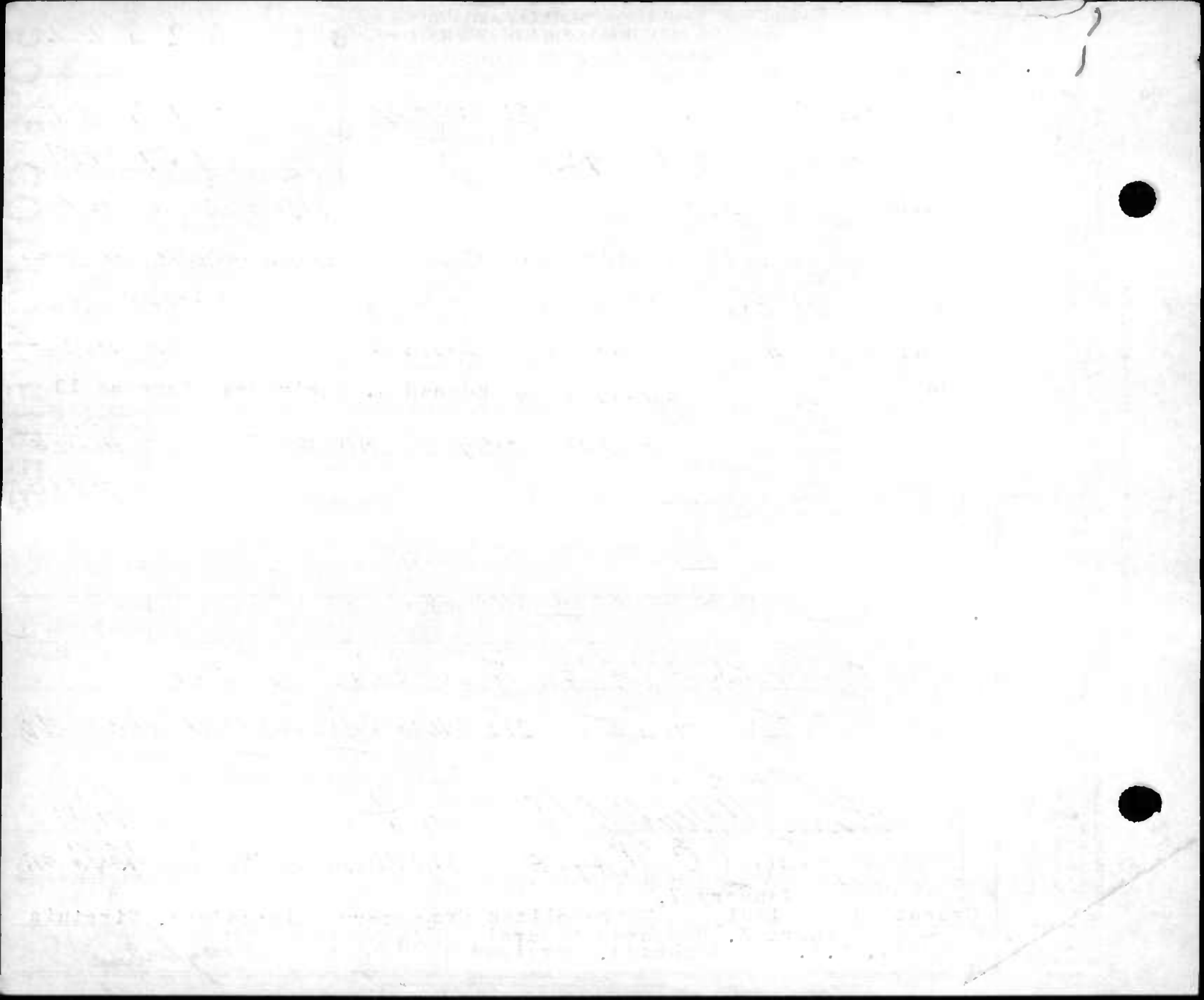
| | | | | | | | | | | |
|---|--|--|---|---|---|-------------------------|---|---------------|-----------------|--------------------------|
| 1 DECEASED NAME
(TYPE AND PRINT) | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | MONTH | DAY | YEAR | 2b HOUR |
| LOUISE | | | HENRIETTA | SEEK | 1 9 81 | | | | | 8:30 P.M. |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | Caucasian | | 5 14 1889 | | 91 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | | | Montgomery | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Silver Spring, MD. | Althea Woodland N.H. Silver Spring, Md. | | Homemaker | | Home | | | | | |
| 13a STATE | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS | | | | | | |
| MD. | Montgomery | Gaithersburg | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 22225 Woodfield Rd. | | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS |
| Charles | | Louise | | | | 217-36-5020 | | Edith Seek | | 8302 Roanoke Takoma Park |
| | | | | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>BRONCHITIS</u> | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19c AUTOPSY? | | 19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b TIME OF INJURY | | 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21a INJURY OCCURRED | | 21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c LOCATION | | CITY OR TOWN | | COUNTY | STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from <u>Jan 9 1981</u> to <u>Jan 9 1981</u> that <u>we</u> saw the deceased alive on <u>Jan 9 1981</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (2) we (did) <u>not</u> visit the body after death. | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | | | | | | |
| Bernard A. Fitzgerald M.D. | | M.D. | | 1/9/81 | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | 22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| BERNARD A. FITZGERALD | | 217 UNIVERSITY BLVD E, SILVER SPRING MD | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | COUNTY | | STATE |
| Burial | | Jan. 12, 1981 | | George Washington | | Adelphi | | Prince George | | MD. |
| 24 FUNERAL DIRECTOR | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | |
| Francis H. Barber Laytonville, Md. 20760 | | JAN 14 1981 | | Anthony McCreedy | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02622 | | | |
|---|--|-----------------------------|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN W. SHEIRBURN | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 1 7 19 81 | | | | 2b. HOUR
A M | | | |
| 3. SEX
FC | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 7 18 62 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 62 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1 7 19 81 | | 2d. HOUR
A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6513 WINNEPEG RD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Home | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6513 WINNEPEG RD | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM A WAGNER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LAVINIA E. DAYMUE | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) No | | 17. INFORMANT ADDRESS
Edmund L. Sheirburn Same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4871
(b) FLU
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-5 DAYS | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
Early AM 1 7 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 48 PART I OR PART 2)
FOUND DEAD IN BED | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6513 WINNEPEG RD BETHESDA MONT MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayke | | | | TITLE (SPECIFY) Dr | | | | MEDICAL EXAMINER DATE SIGNED 1/7/81 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYKE | | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
January 7, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alexandria, Virginia | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey
ADDRESS Homes, P.A. Bethesda, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR
JAN 12 1981 | | | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | | | | |





1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 2 3

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SARAH E. SHERR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-23-81 | | | 2b. HOUR
9¹⁰ P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 27 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
77 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
#516
8201 16th Street Silver Spring, Md | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY SHERR | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
JENNIE RINESS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-60-0763 | | 17. INFORMANT
MRS. DOROTHY SHERR | | ADDRESS
2445 LYTONSVILLE ROAD,
APT. NO. 301
SILVER SPRING, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
1569
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Carcinoma of Biliary tract
DUE TO, OR AS A CONSEQUENCE OF
(c) 5 Months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
None | | | | | | | | | |
| 19a. DATE OF OPERATION
8/5/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of Biliary tract | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 15 , 19 65 , to 1/23 , 19 81 , that (I) (we) lost
saw the deceased alive on 1/23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Max G. Sherr MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/23/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MAX G. SHERER MD | | | | 22e. ADDRESS
800 Pershing Drive Silver Spring, Md 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
BURIAL | | 23b. DATE
1/26/1981 | | 23c. NAME OF CEMETERY
CONGREGATION SHEV SHOLOM TALMUD TORAH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON, D. C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Donald M. Stein Hebrew Memorial F.H. | | | | 25a. DATE BY REGISTRY
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

5200
BP
DHHM-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8102624 | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) AGNES Luckett SHIELDS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 4, 1981 | | 2b. HOUR A M
3:20 A | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
July 14 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chevy Chase Convalescent Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John B. Luckett | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Caroline Clements | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO
215-36-4859 | | 17. INFORMANT ADDRESS
Brother John L. Luckett same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular collapse - acute
3483
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) myocardial infarction - circulatory
(c) of the liver - severe degeneration | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (in this hospital) attended the deceased from 12/30 , 19 80 , to 1/4 , 19 81 , that (I) (we) last saw the deceased alive on 1/3 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE DR. Joseph M. Socinas
DR. George Keaton | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/4/1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH M. SOCINAS, MD | | | | | | 22e. ADDRESS
9801 GEORGIA AVE., S.S. MD., 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Jan 6 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr Geo Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Francis J. Collins | | | | | | 24b. DATE REC'D. BY REGISTRAR
JAN 5 1981 | | 24c. REGISTRAR'S SIGNATURE
Anthony Kennedy | | | |
| 25. ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at which

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 6 2 5

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ROSE

SHNIDER

2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 31, 19812b. HOUR
2:30 AM

3 SEX

FEMALE

4 RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH DAY YEAR
MAY 25, 1898

6. AGE (IN YEARS LAST BIRTHDAY)

82 YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)

POLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY COUNTY, MD.

10. CITY OR TOWN OF DEATH

SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1135 UNIVERSITY BOULEVARD, WEST

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

MERCHANT

12b. KIND OF BUSINESS OR
INDUSTRY

GROCERY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MARYLAND13b. COUNTY
MONTGOMERY13c. CITY OR TOWN
SILVER SPRING13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS

1135 UNIVERSITY BOULEVARD, WEST

14. FATHER'S NAME

VISROEL

MIDDLE

BRONSTEN

15. MOTHER'S MAIDEN NAME

EVA

MIDDLE

(UNASCERTAINABLE)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.

579-38-8733

17. INFORMANT

ADDRESS

BENJAMIN SHNIDER, same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CONGESTIVE HEART FAILURE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 YEAR

DUE TO, OR AS A CONSEQUENCE OF

(b) HYPERTENSIVE CARDIOVASCULAR DISEASE

15 YRS.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 1955, 19, to JAN 31, 1981, that (I) (we) last
saw the deceased alive on JAN 29, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Saul Zuckerman MD

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐22c. DATE SIGNED 1981
JANUARY 31, D.C.

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SAUL ZUCKERMAN, M.D.

22e. ADDRESS

5410 CONNECTICUT AVENUE, N.W., WASHINGTON, D.C.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

2/1/1981

23c. NAME OF CEMETERY OR CREMATORY

NATIONAL CAPITOL HEBREW CEMETERY

23d. LOCATION
CITY OR TOWN

WASHINGTON, D.C.

COUNTY

STATE

24. PLACE OF FUNERAL SERVICE
NAME
DOMINIC M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C.25a. DATE REC'D. BY REGISTRAR
FEB 4 1981

25b. REGISTRAR'S SIGNATURE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 2 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIE MAY MAY SICHERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 28 81 | | | 2b. HOUR
7 43 PM | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 10, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp., Silver Spring Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
BAKERY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
SILVER SPRING | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM C. TANNEHILL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIRGINIA JACOBS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | |
| 16b. SOCIAL SECURITY NO.
578-24-8325 | | | 17. INFORMANT
JOSEPH SICHERT | | | 17. ADDRESS
SAME AS 13 HUSBAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction 4 hrs</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Coronary Artery Disease years</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus, Hypertension</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 76 G.K.</u> to <u>1/28 81</u> , that (I) (we) last saw the deceased alive on <u>NOV 30 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN I. KERMAIER, MD | | | | | | 22c. DATE SIGNED
1/28/81 | | 22d. ADDRESS
9801 GEORGIA AVE. SS MD 20902 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1/31/81 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR GROVE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BEALETON VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS
500 UNIVERSITY BOULEVARD WEST, SILVER SPRING, MD. | | | | | | 25a. FILED BY REGISTRAR
FEB 3 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any other cause of death, a medical examiner must be notified.

shared by ME. G. Kermayer



1837 C 837

0000

DHHM-16 25M
(VRA 15, 4) 1/79FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 2 7

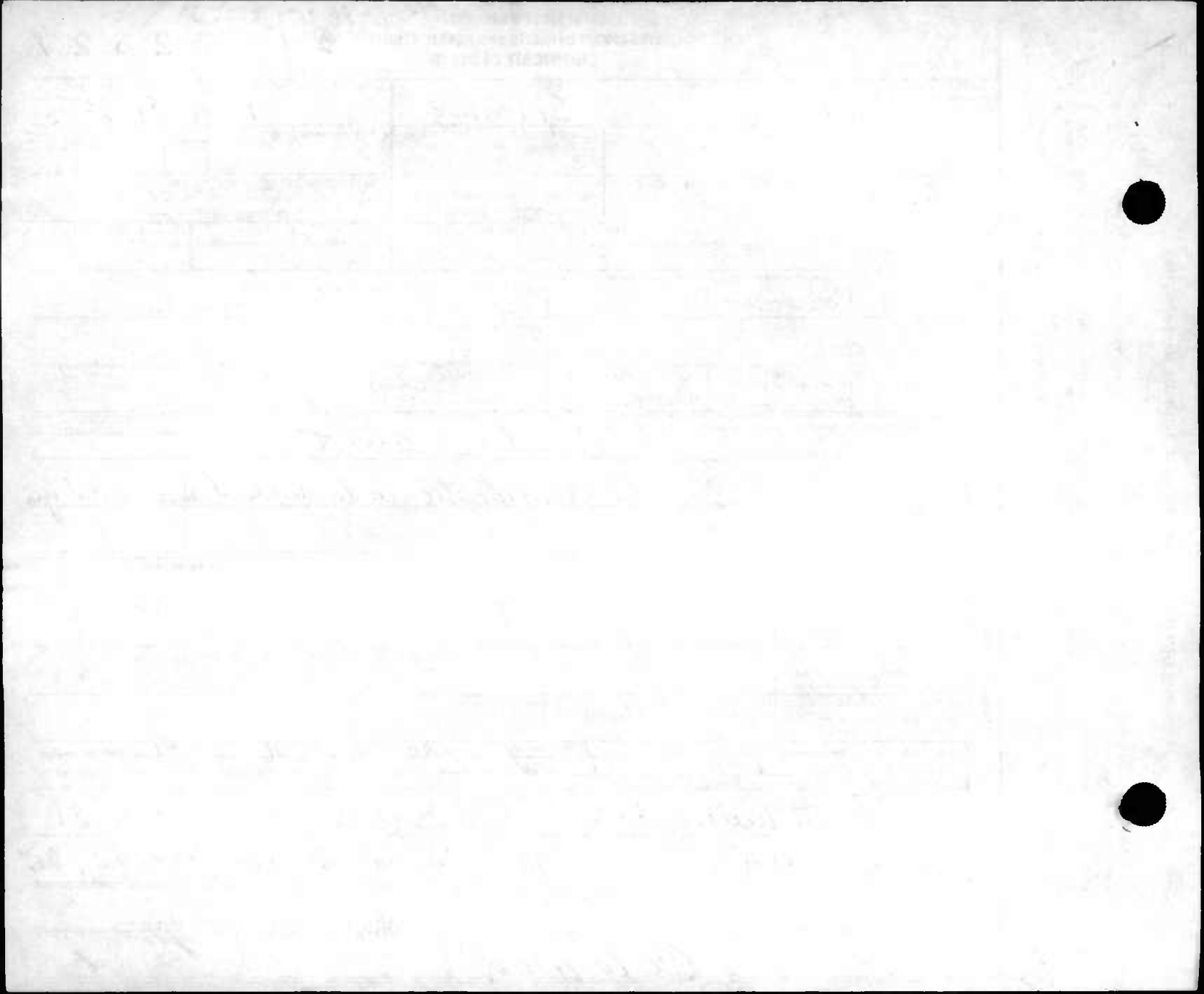
REG. NO.

| | | | | | | | | | |
|--|--|--|---|--|--------------------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Natalia Silins</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1 11 81</i> | | | 2b. HOUR
<i>6:25 PM</i> | | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR
<i>3 10 1885</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<i>95</i> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 2 YRS HRS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Latvia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>Latvia</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Takoma Park</i> MD. | | | |
| 10 CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sligo Gardens Nursing Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Tk. Park</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST (unknown) MIDDLE LAST Vanags | | | 15 MOTHER'S MAIDEN NAME
FIRST Ilze MIDDLE LAST (unknown) | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>no</i> | | | |
| 16b. SOCIAL SECURITY NO
<i>578-44-3105</i> | | | 17 INFORMANT (son) ADDRESS
<i>Andrejs Silins-(same as 13e)</i> | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>
4292
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardio-vascular disease several yrs</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dehydration, senility</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-9 1980</i> to <i>1-11 1981</i> , that (I) (we) last saw the deceased alive on <i>1-11 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Eino Magi</i> | | | | DEGREE | | 22c. DATE SIGNED
<i>1-11-81</i> | | 22d. ADDRESS
<i>11120 New Hampshire Ave. Silver Spring, Md</i> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>EINO MAGI</i> | | 22f. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1-15-1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Washington, D.C.</i> | | 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, INC.</i>
<i>8434 Ga. Ave., S.S. Md.</i> | |
| 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | | | | |

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 2 8

REG. NO.

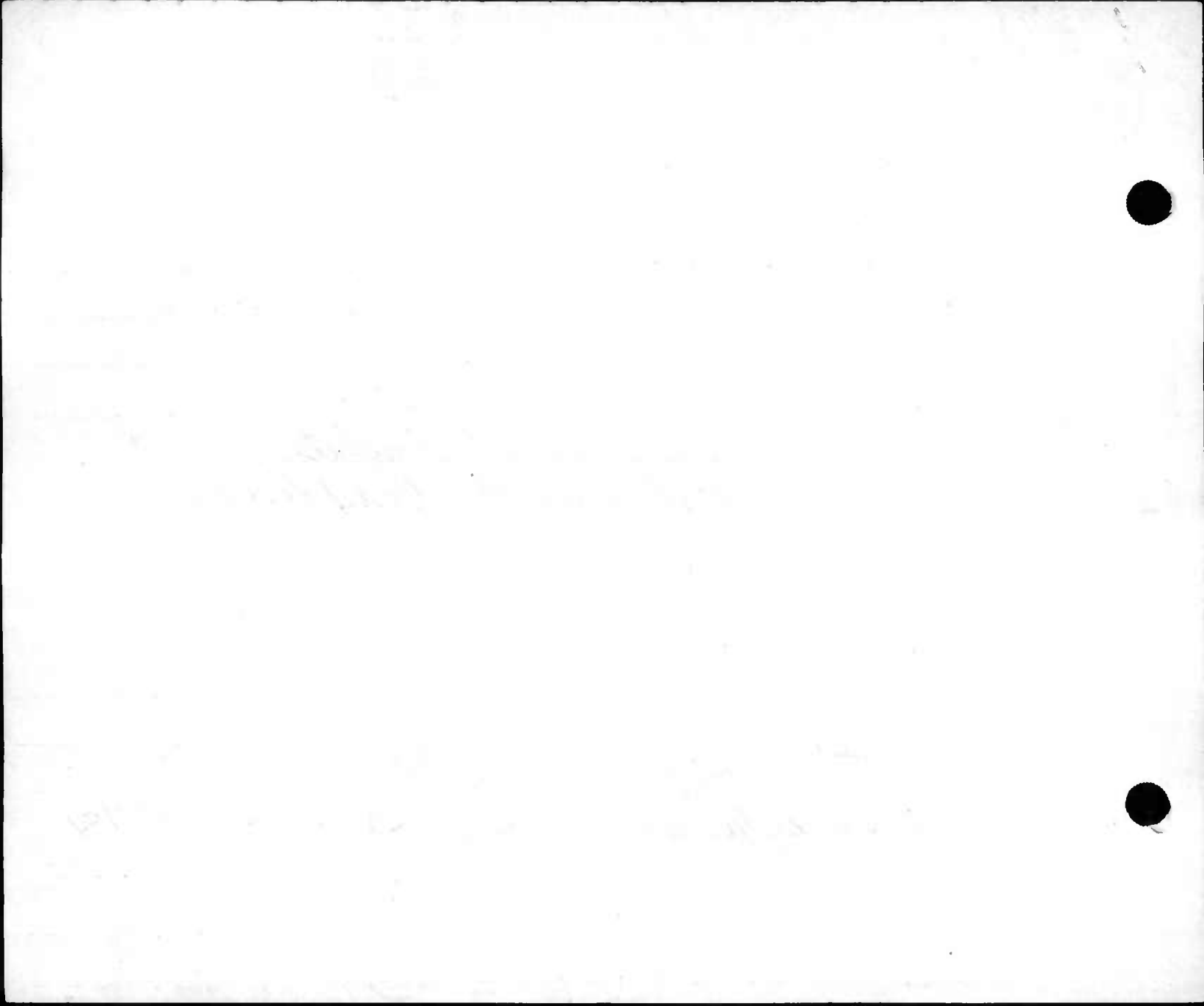
1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|---|---|------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Lee Skiados | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 7, 1981 | | 2b. HOUR
12:05 P.M. |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
6 18 1909 | 6 AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mississippi | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Kensington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10401 Meridith Avenue, | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Kensington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
10401 Meridith Avenue, | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William F. Garden | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Belle Donald | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
(# YES, GIVE WAR OR DATES)
----- 224-60-2068 | 17 INFORMANT (daughter) ADDRESS
Evangeline Miller-(same as 13e) | | | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Unbridled Fibrillation</u>
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | | | |
|---|--|--|--|--|----------------------------|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>12/3/80</u> to <u>1/7/81</u> , that (1) (we) last saw the deceased alive on <u>12/3/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Stanley M. Silvergerg</u> | | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/8/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STANLEY M. SILVERGERG, M. D. | | 22e. ADDRESS
5530 WISCONSIN AVE. CHEVY CHASE, MD. 20015 | | | |

| | | | |
|--|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1-9-1981 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md. |
| 24 FUNERAL DIRECTOR
Warner E. Pumphrey, INC.
8434 Ga. Ave., S.S. Md. | | 25a. DATE FILED BY REGISTRAR
JAN 15 1981
25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 6 2 9

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bradley B. Smith SR. | | 2a. DATE OF DEATH
MONTH 1 DAY 27 YEAR 81 | | 2b. HOUR
9:15 P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH JUNE DAY 21 YEAR 1902 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS 78 DAYS 78 | | IF UNDER 24 HRS.
HOURS 78 MIN. 78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGEMENT ANALYST | | 12b. KIND OF BUSINESS OR INDUSTRY
CIVIL SERVICE | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1809 SHERWOOD ROAD | | | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE D. LAST SMITH | | 15. MOTHER'S MAIDEN NAME
FIRST SALLIE MIDDLE E. LAST BRADLEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-44-3762 | | 17. INFORMANT
HOPE R. SMITH ADDRESS SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4241
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterio Sclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
NO | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 19 78 , to 1-27 19 81 , that (I) (we) lost saw the deceased alive on 1-27 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Daniel J. Boyle MD | | | | 22c. DATE SIGNED
1-27-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL BOYLE | | | | 22e. ADDRESS
CHEVY CHASE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/31/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
TOWN SILVER SPRING COUNTY MONT STATE MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Patricia H. Harty | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Charlie</u> MIDDLE <u>G.</u> LAST <u>Smith</u> | | 2a. DATE OF DEATH
MONTH <u>JAN.</u> DAY <u>19</u> YEAR <u>81</u> | | 2b. HOUR
<u>11⁰⁰</u> AM | |
| 3. SEX
<u>M</u> | 4. RACE
<u>Cauc</u> | 5. DATE OF BIRTH
MONTH <u>Mar.</u> DAY <u>4</u> YEAR <u>1895</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>85</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>N. Carolina</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
<u>OLNEY</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Brooke Grove N.H.</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery,</u> MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Govt.</u> | | | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Sil. Spring</u> | |
| 14. FATHER'S NAME
FIRST <u>Robert</u> MIDDLE <u>C.</u> LAST <u>Smith</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Mintoria</u> MIDDLE <u>Richardson</u> LAST <u>Richardson</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>yes</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
<u>WW1</u> | | 17. INFORMANT (wife) ADDRESS
<u>Neville P. Smith-(same as 13e)</u> | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u>
<u>4409</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Diffuse Atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>20 years</u> |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

① Obstructive Airways Disease ② Embolus Lung Disease

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12, 1980</u> to <u>Jan. 19, 1981</u> , that (I) (we) lost saw the deceased alive on <u>Jan 19, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Frank J. Mayo</u> | DEGREE
<u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1-19-81</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Frank J. Mayo, M.D.</u> | | 22e. ADDRESS
<u>16220 Frederick Road Gaithersburg, Maryland 20760</u> | |

| | | | |
|--|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | 23b. DATE
<u>1-20-1981</u> | 23c. NAME OF CHURCH OR CREMATORY
<u>Metropolitan</u> | 23d. LOCATION
CITY OR TOWN <u>Landover</u> COUNTY <u>Prince Georges</u> STATE <u>Virginia</u> |
| 24. FUNERAL DIRECTOR
NAME <u>Warner P. Pumphrey, Inc.</u>
<u>8434 Ga. Ave., S.S. Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 22 1981</u> | |

COLLEGE

[Faint, mostly illegible text covering the main body of the page, possibly bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 2 6 3 1
CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) DONALD MORA SMITH | | | 2a. DATE OF DEATH
Month JANUARY Day 19 Year 1981 | | 2b. HOUR
9:30 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Jan. 4 1906 | | 6. AGE (In years last birthday)
75 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
13251 VENETIAN ROAD | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Postal Ser. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER
13251 VENETIAN ROAD | |
| 14. FATHER'S NAME First Middle Last
Not Known Smith. | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Not Available. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
8810 Falstone Dr. Frederick, Md.
Kenneth W. Smith. (Son) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1990 IMMEDIATE CAUSE (a) Carcinomatosis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12 , 19 80 , to 1/19 , 19 81 , that (I) (we) last saw the deceased alive on 1/12 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Daniel Rosenblum MD DEGREE | | | | 22c. DATE SIGNED
1/19/81 | |
| 22d. PHYSICIAN'S NAME (Type)
DANIEL ROSENBLUM | | | | 22e. ADDRESS
10400 CONNECUT AV
KENSINGTON, MD 20795 | |
| 23a. BURIAL (CREMATION)
CREMATION | | 23b. DATE
Jan. 21, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Crematory | |
| 23d. LOCATION (City or Town)
Bladensburg Rd. P. Geo | | 23e. ADDRESS
Takoma Funeral Home.
254 Carroll St. N. W. | | 23f. REC'D BY REGISTRAR
JAN 22 1981 | |
| 23g. REGISTRAR'S SIGNATURE
Arthur J. Walters | | 23h. REGISTRAR'S SIGNATURE
Arthur J. Walters Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CRIMINAL RECORD

1900
1901
1902
1903
1904
1905
1906
1907
1908
1909
1910
1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

81 02632

| | | | | | | | | |
|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Lucille v. Smith</i> | | | 2r. DATE OF DEATH MONTH DAY YEAR
<i>January - 3-81</i> | | | 2b. HOUR
<i>12²⁵ AM</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>July-8-04</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
<i>76</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Co.</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hosp.</i> | | | 12a. USUAL OCCUPATION/
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | |
| 13a. STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>William Frank Smith</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Fanny Gertrude Mereness</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>577 12 6889</i> | | 17. INFORMANT
<i>William Smith</i> | | ADDRESS
<i>9232 Villa Dr. Bethesda, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CORONARY thrombosis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CORONARY Atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>BRADYCARDIA - Tachycardia syndrome with Pacer maker</i> | | | | | | | | |
| 19a. DATE OF OPERATION
<i>—</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>—</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. — 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>—</i> | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>—</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
<i>—</i> | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> 19 <i>80</i> to <i>JAN-2</i> 19 <i>81</i> , that (I) (we) lost
saw the deceased alive on <i>JAN 2</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE DEGREE
<i>Roland Imperial MD</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-3-81</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ROLAND IMPERIAL</i> | | | | 22e. ADDRESS
<i>MD 20814 H977 BATTERY Lane Bethesda</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>Jan 4, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Metropolitan Crematory</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Alexandria Virginia</i> | | |
| 24. FUNERAL DIRECTOR NAME
<i>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 7 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Robert A. Pumphrey</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

January

STANDARD METEOROLOGICAL BUREAU
WASHINGTON, D.C.

1911
JANUARY 1st
1911

1911

1911

1911

1911

1911

1911

1911

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 3 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Sister Mary Clarus Smyth, c.s.c. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 3 1981 | | | 2b. HOUR
3:00 A.M. | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 18, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5000 Strathmore Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher - Nun | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5000 Strathmore Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony Smyth | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Smith | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
226-76-5173 | | | 17. INFORMANT
ADDRESS
Sister Maureen Patrice, C.S.C. same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5715 Gastrointestinal Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophageal Varices
DUE TO, OR AS A CONSEQUENCE OF
(c) Hepatic Cirrhosis | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 weeks
6 months
2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes Mellitus, Arteriosclerotic Heart Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21/81 to 1/31/81, that (we) last saw the deceased alive on 1/21/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Macon | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/31/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Macon | | | | | 22e. ADDRESS
809 Niers Mill Rd. Rockville, Md. 20851 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Jan. 6, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1981 | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | 25b. REGISTRAR'S SIGNATURE
Anthony McReddy | | | | |

2

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

Washington
5000 Connecticut Avenue
Teacher - Mrs.
1902
1902

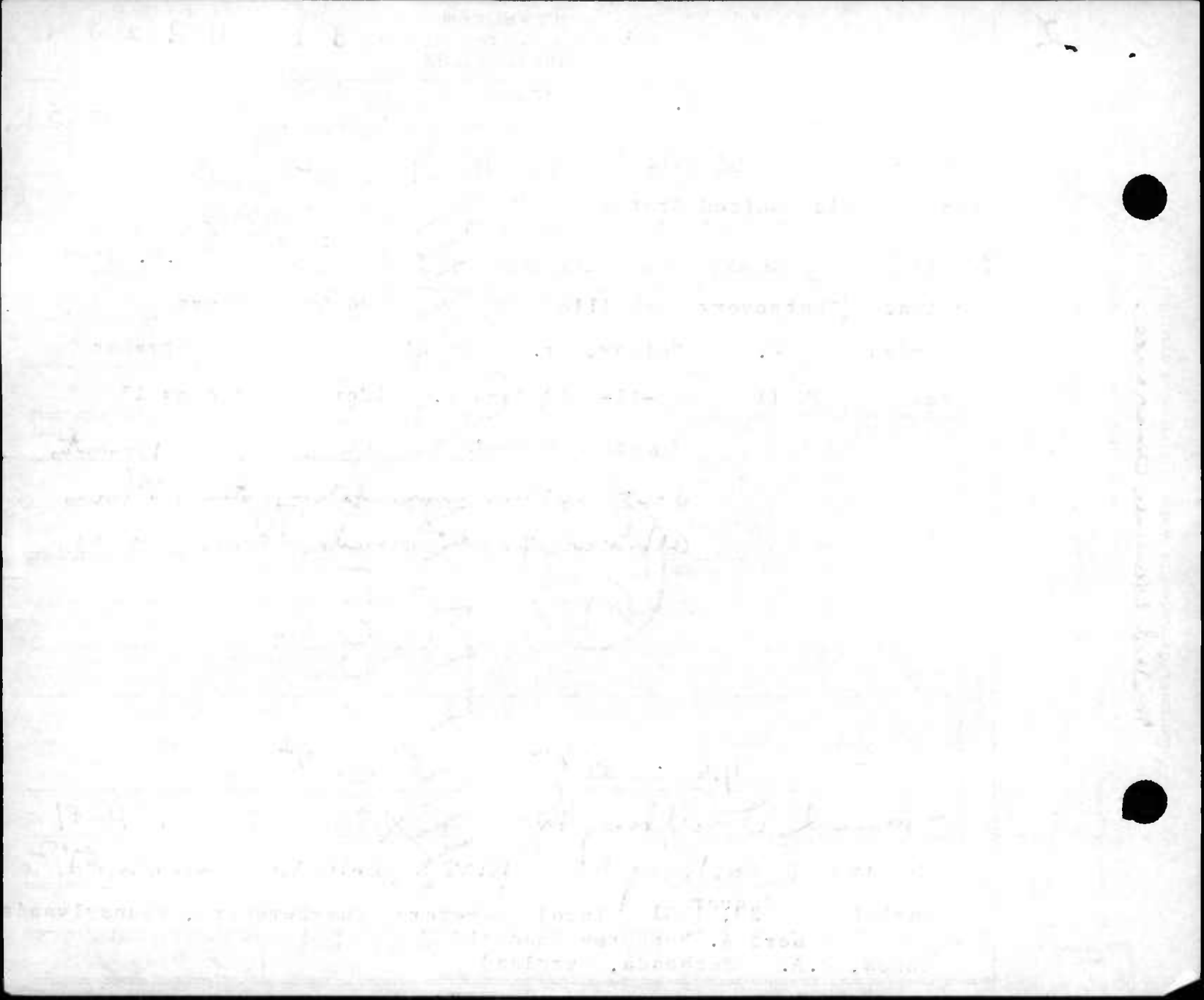
Medical Examiner Examined

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR --)
FIRST MIDDLE LAST
JACOB H. SNIDER | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
01 16 81 | | | 2b. HOUR
1523 M | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 24 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | | | 12a. USUAL OCCUPATION (WORKING LIFE)
Electrical Technician | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
#6 Lynch Court | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ralph K. Snider, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Hatmaker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WW II | | 17. INFORMANT
Jean E. Snider | | ADDRESS
Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Acute anterior myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) atherosclerotic cardiovascular disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 minutes
18 hours
years. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16 , 19 81 , to 1/16 , 19 81 , that (we) last saw the deceased alive on 1/16 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Samuel D. Goldberg MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
1-16-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Samuel D. Goldberg MD | | | | 22e. ADDRESS
11125 Rockville Pike, Rockville, Md. 20852 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
January 20, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chambersburg, Pennsylvania | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. | | | | ADDRESS
Bethesda, Maryland | | 25. DATE & SIGNATURE OF REGISTRAR
JAN 21 1981 | | | | | |



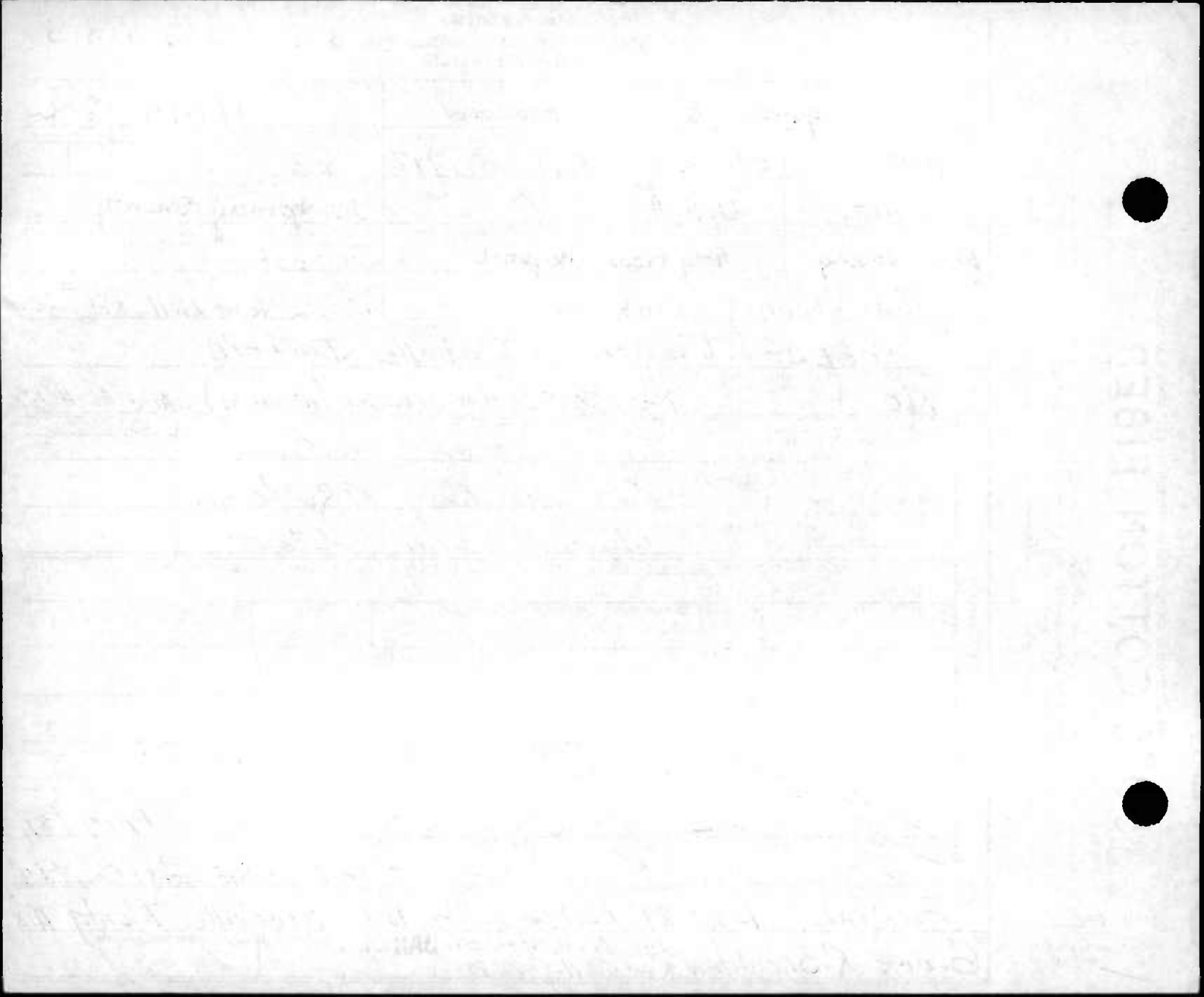
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 2 6 3 5 | |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
space E. Snowden | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/19/81 | | 2b. HOUR
8:25 PM |
| 3. SEX
female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 25, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Johns Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT JOHNSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isabelle Daffin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-32-7078 | | 17. INFORMANT
ADDRESS
Luther Snowden (Husband) SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Renal failure</u>
4039
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Dehydration, azotemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension, Gent</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 4, 1980</u> to <u>Jan. 19, 1981</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Boo K. Kim</u>
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/19/81 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
1-22-81 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montg. Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden
ADDRESS
246 N. WASH. ST. ROCKVILLE, MD. | | | | | |

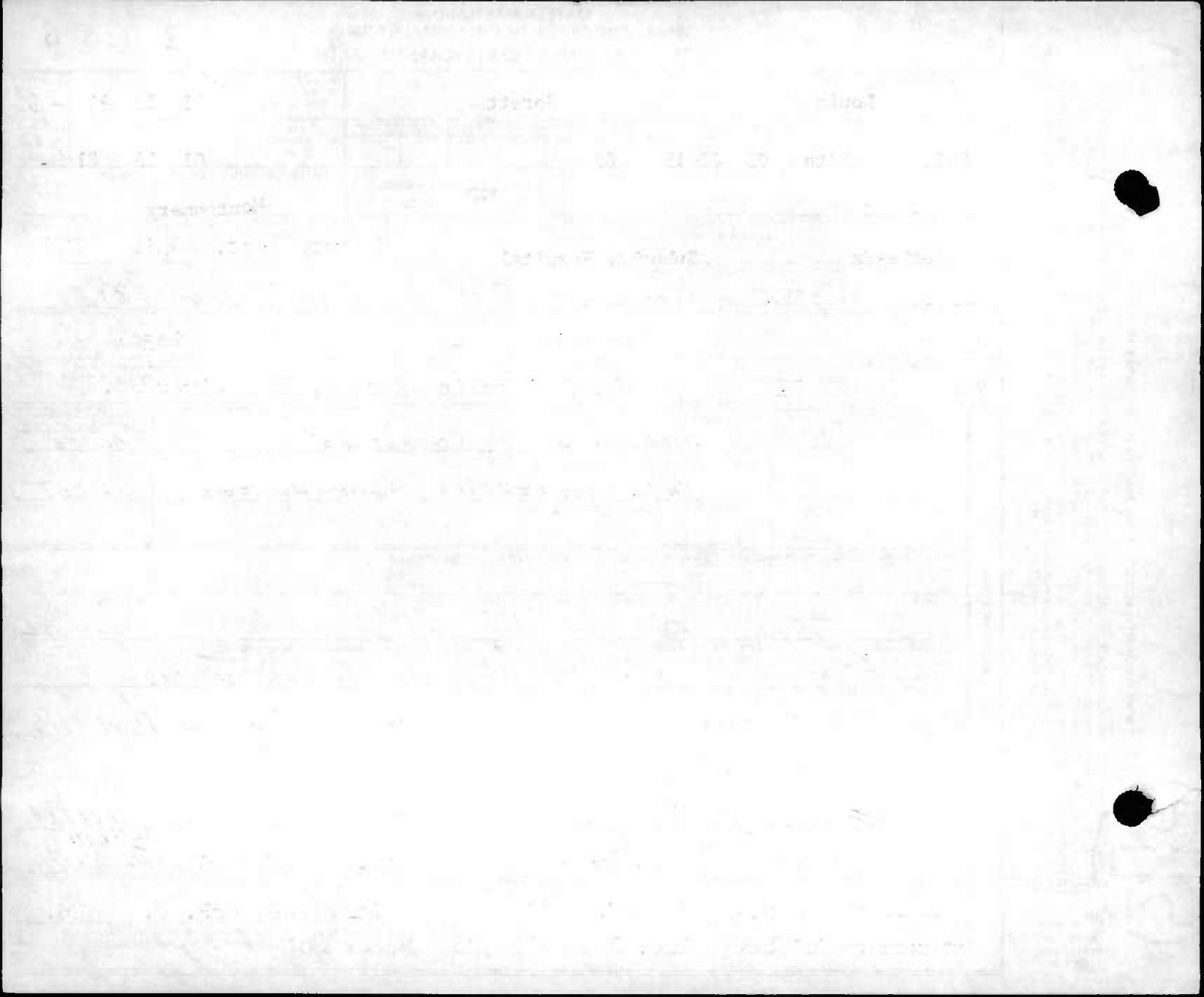


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M/77

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---------|--|---|--|---|--|---|--|------------------|--|
| 1- STATE REGISTRAR
FOR item 5 p/ph 2/9/81 w/fh | | | | | | | | | | | |
| REG. NO. 02636 | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE KNOWN OF DEATH | | | | | |
| FIRST MIDDLE LAST | | | | | | MONTH DAY YEAR | | | | | |
| Louis Sorett | | | | | | 01 18 1981 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | |
| Male | | White | | MONTH YEAR | | LAST BIRTHDAY | | MONTHS DAYS | | HOURS MIN. | |
| 05 12 15 | | 65 YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| New Jersey | | | | USA | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR DEPUTY OF WORKING LIFE) | | | |
| Bethesda | | | | Suburban Hospital | | | | Deputy Asst. Admin OMB | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| D.C. | | | | XXXXXX | | | | Washington | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | 13e. STREET ADDRESS | | | |
| Hyman | | | | Lastotsky | | | | Anna Siegal | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| Yes | | | | WW II | | | | Washington, DC | | | |
| | | | | 040-16-5017 | | | | Felice Sorett, 4220 River Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| 4100 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) ARTERIOSCLEROSIS GENERALIZED | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | P.M. 1 18 1981 | | | | COLLAPSED PLAYING TENNIS | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | TENNIS CLUB | | | | CARSON JOHN TENNIS CLUB PINEHURST MOUNT MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | |
| Francis C. Mayle | | | | | | M.D. Asst. MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | DATE SIGNED | | | | | |
| Francis C. Mayle | | | | | | 11/18/81 | | | | | |
| ADDRESS | | | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | |
| 8200 Wisconsin Ave Bethesda MD | | | | | | Cremation | | | | | |
| 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Jan. 19 '81 | | | | | | Cedar Hill | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | 24. FUNERAL DIRECTOR | | | | | |
| Suitland, P. G. Md. | | | | | | Danzansky-Goldberg, Inc. Rockville, Md | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| JAN 23 1981 | | | | | | [Signature] | | | | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LENI L Southworth | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 7 1981 | | 2b. HOUR
8 ²⁰ AM |
| 3. SEX
FEMALE | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
5 18 86 | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | 13c. CITY OR TOWN
Montgomery | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
222 Granville Drive, | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James B. Gilbert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Belle Grady | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
579-03-4085 | | 17. INFORMANT (son) ADDRESS
5022 Sangamore
Gilbert L. Southworth-Rd., Beth., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Heart Failure</u>
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Chronic Artery Dis</u>
(c) <u>yes</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3700 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> 19 <u>87</u> , to <u>1/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Richard Coiffi</u> | | DEGREE | | 22c. DATE SIGNED
1/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD COIFFI
XXXXXXXXXXXXXXXXXXXX MD | | 22e. ADDRESS
10620 Georgia Avenue,
Silver Spring, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-10-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md. | | 24. FUNERAL HOME
Warner E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md. | | | |
| 25a. DATED BY REGISTRAR
JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>John E. Balon</u> | | | |

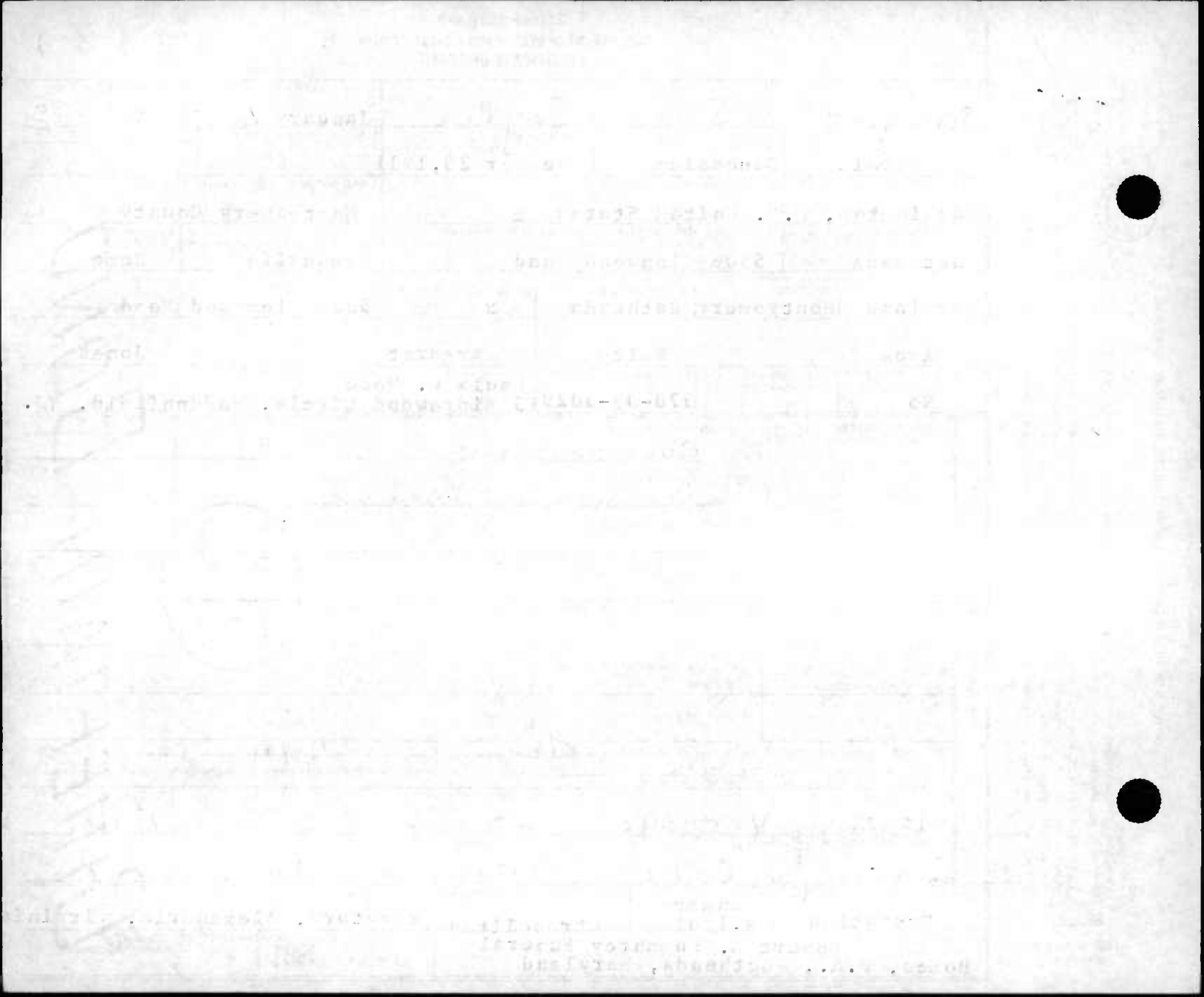


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 2 6 3 8 | | | |
|--|--|---|--|--|--|---|--|---|--|--|-----|------------|----------|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Margaret | | S. | | Saylor | | | | January | | 4 | 81 | 6 30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | Caucasian | | November 23, 1911 | | 69 YRS. | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Washington, D.C. | | United States | | DIVORCED <input type="checkbox"/> | | Montgomery County | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | 5506 Glenwood Road | | Housewife | | Home | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5506 Glenwood Road | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Amos | | Smith | | Margaret | | Jones | | Paula C. Wood | | 13 Ridgewood Circle, Haddonfield, N.J. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 1541
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.
(b) <u>Carcinoma of Rectum</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/80, 19, to 1/4/81, 19, that (I) (we) lost
saw the deceased alive on 12/2/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Jeremy V. Coolce | | DEGREE
MD | | 22c. DATE SIGNED
1/4/81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Jeremy V. Coolce | | 10400 Conn Ave. Kensington | | Cremation | | January 4, 1981 | | Metropolitan | | Crematory, Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Robert A. Pumphrey Funeral
Homes, P.A., Bethesda, Maryland | | JAN 7 1981 | | [Signature] | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

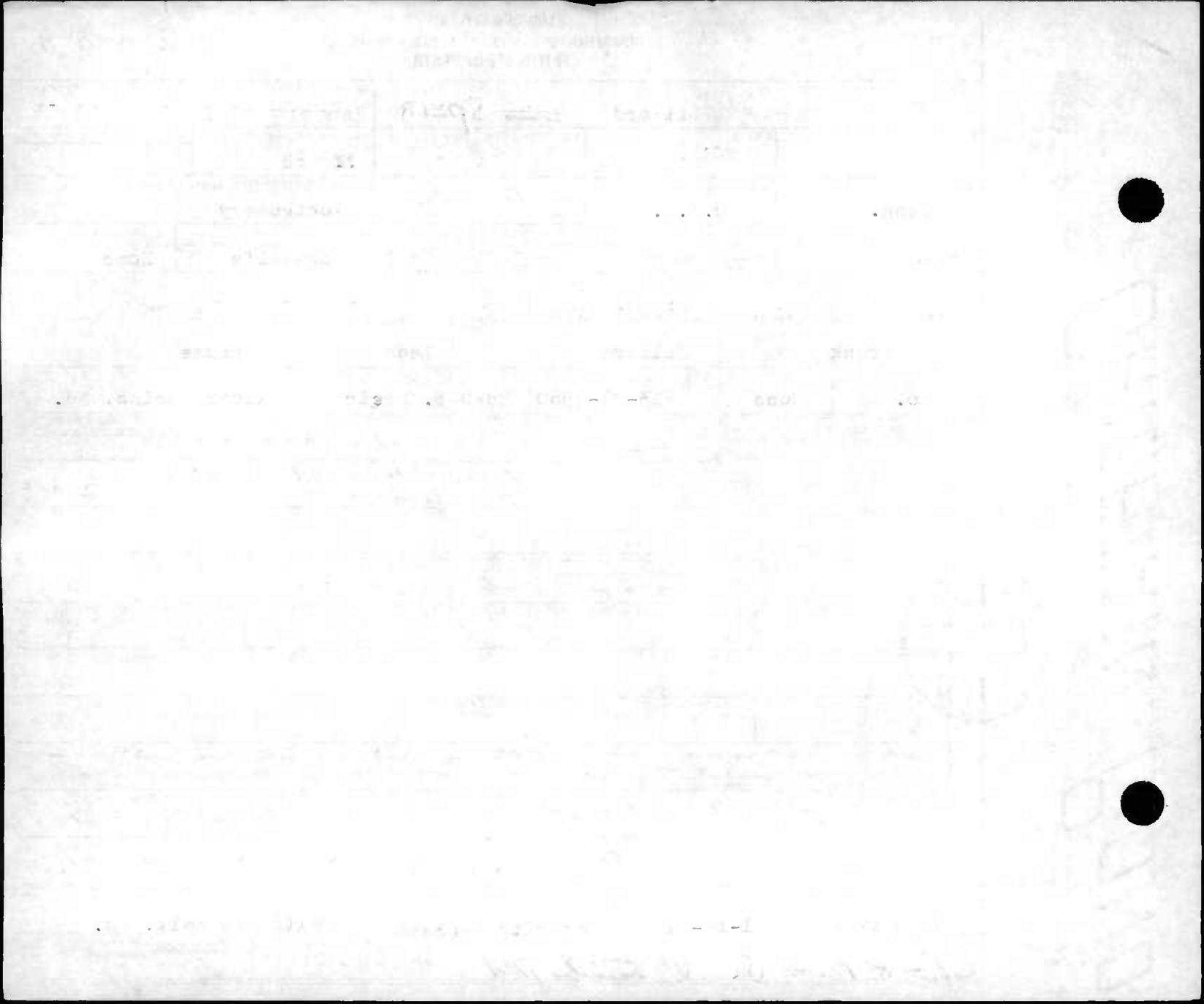
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 3 9

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Dillard Speir | | | 2a DATE OF DEATH
MONTH DAY YEAR
January 13 1981 | | 2b HOUR
MIN.
11:15^a | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
4 19 98 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tenn. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 82 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | | |
| 13a STATE
Md. | | 13b COUNTY
Mont. | | 13c CITY OR TOWN
Silver Spring | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Frank Dillard | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leda House | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. None | | 16b SOCIAL SECURITY NO.
213-24-9560 | | 17 INFORMANT
ADDRESS
Hugh B. Speir Sliver Spring, Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute my. cardiac infarction
4100
DUE TO, OR AS A CONSEQUENCE OF complete Heart Block failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Carcinoma of Breasts. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 78 to 9 Dec 19 80 that (I) was last saw the deceased alive on 9 Dec 19 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Gustavo S. Belaur DEGREE MD | | | | 22c. DATE SIGNED
13 Jan 81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GUSTAVO S. BELAUR | | | | 22e. ADDRESS
3701 Rossmoor Blvd., Silver Spring, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1-14-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Balt. Md. | | | | | | |
| 24 FUNERAL DIRECTOR
NAME
Robert K. Pirota Sr. | | ADDRESS
Westminster, Md. | | 25a. DATE REC'D BY REGISTRAR
JAN 20 1981 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | | |



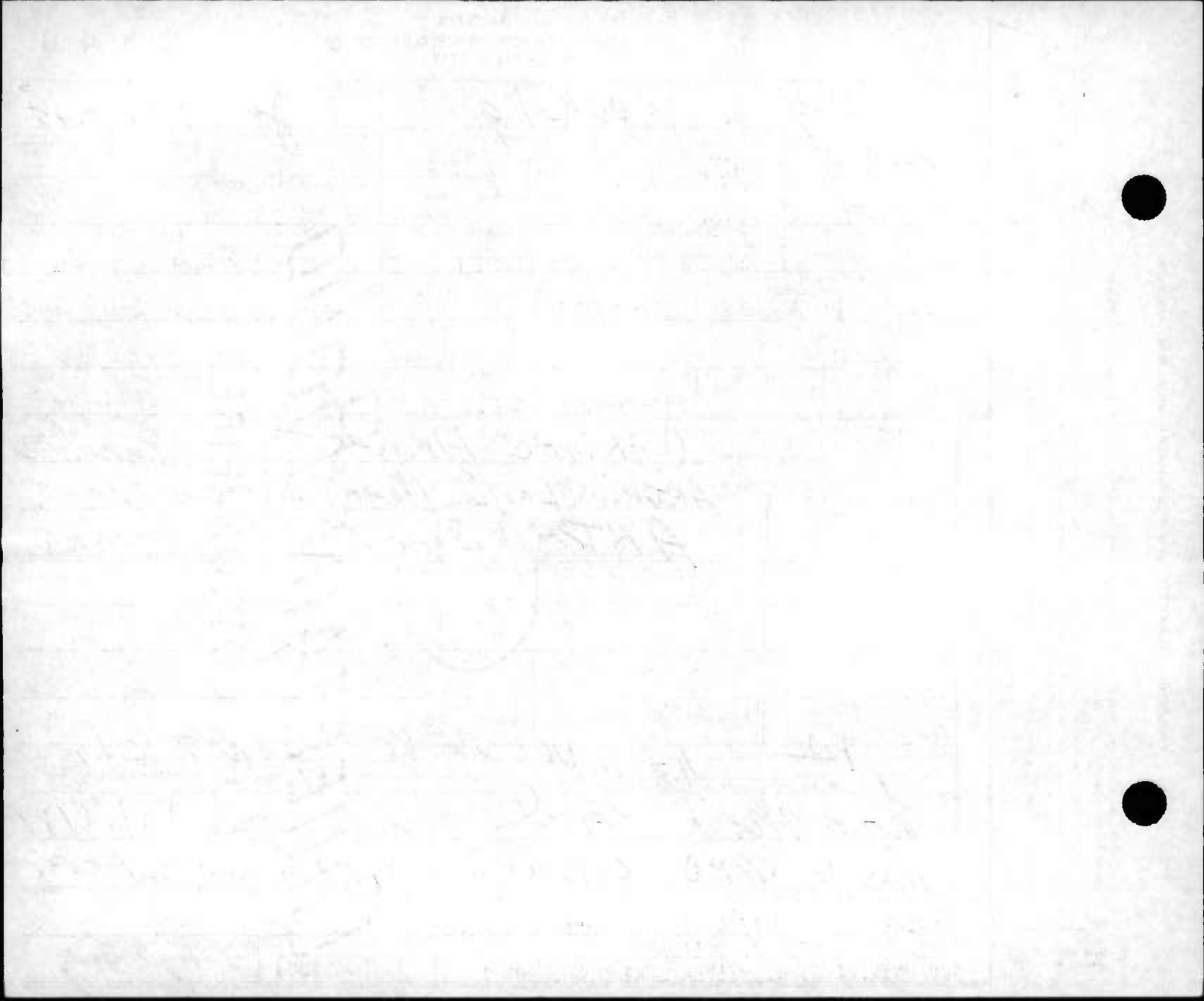
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 2 6 4 0 | |
|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| Muy G. SPOKELY | | | | Jan 17 '81 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | WHITE | | JULY 31, 1899 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MINNESOTA | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| KENSINGTON | | KENSINGTON GARDENS NURSING HOME | | EDUCATIONAL & FIELD REP FORD CO | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| ALBERT | | HANNAH | | NO | |
| 17. INFORMANT | | 18. SOCIAL SECURITY NO. | | 19. ADDRESS | |
| SON | | 428-09-0578 | | 3832 TREMAYNE TR. SILVER SPRING MD. | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>ARTERIOSCLEROSIS</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 23a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 23c. LOCATION (CITY OR TOWN, COUNTY, STATE) | |
| | | | | | |
| 24. I certify that (I, the undersigned) attended the deceased from <u>Dec 26 19 80</u> to <u>Jan 17 19 81</u> , that (I) (we) last saw the deceased alive on <u>1/13/81</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did not) view the body after death. | | | | | |
| 25. SIGNATURE | | | | 26. DATE SIGNED | |
| Thos G. Ward | | | | 1/18/81 | |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 28. ADDRESS | |
| Thos G. Ward | | | | 6116 Robbinswood, Bethesda, Md 20034 | |
| 29a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 29b. DATE | | 29c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 1/20/81 | | PARKLAWN CEMETERY | |
| 30a. FUNERAL DIRECTOR NAME | | 30b. DATE REC'D BY REGISTRAR | | 30c. REGISTRAR'S SIGNATURE | |
| RANCIS J. COLLINS | | JAN 22 1981 | | Randy M. Mundy | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 6 4 1

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Felix E. SPURNEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 31, 1981 | | 2b. HOUR
7:45 AM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
December 25, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
78 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Civil Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Manufacturing Butler |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Kensington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4304 Glenrose Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Petr Spurney | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Johana Hauser | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-03-2469 | | 17. INFORMANT
ADDRESS
Susan Taylor 10621 Mantz Road Silver Spring, MD. 20903 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
REV. 7/25 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ARTERIOSCLEROTIC CEREBROVASC. DIS. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 31, 1981 to January 31, 1981 , that (I) (we) lost the deceased on January 31, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard H. Pollen | | DEGREE
MD | | 22c. DATE SIGNED
1-31-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD H. POLLEN | | 22e. ADDRESS
10400 CONNECTICUT AV, KENSINGTON, MD 20745 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
February 1, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory, Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 1 0 2 6 4 2 | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| GEORGE STANFORD | | 1-28-81 | | 9:35 P | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| M | White. | 3 07 16 | 64 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pierri South Dakota, U. S. | | | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | Holy Cross Hospital | Soil Scientist Dept. Agric. | Dept. Agric. | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Montg. | Silver Spring | NO <input type="checkbox"/> | 9215 Wendell St. | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| Andrew J. Stanford. | Emma Puryear. | Yes. | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 480-30-5753 | | Helen M. Stanford. (Wife) 13 e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
2028
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acidosis, Azotemia</u>
4 mo
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Myeloid metaplasia</u>
10 yr | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Malignant Lymphoma</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 1/26/81 | Lymph node biopsy - | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> 19 <u>81</u> , to <u>1/28</u> 19 <u>81</u> , that (I) (we) lost
saw the deceased alive on <u>1/23</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | 22c. DATE SIGNED | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | |
| <u>[Signature]</u> | 1/29/81 | <u>[Signature]</u> | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | |
| | | | | | |
| 23. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Cremation. | Jan. 30, 1981 | Ft. Lincoln | Bladensburg Rd. P. Geo. Md. | | |
| 24. FUNERAL DIRECTOR
NAME | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>[Signature]</u> | | Feb 5 1981 | | <u>[Signature]</u> | |



THE SOUTH EAST

... ..

... ..

... ..



... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. Mark

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8102643 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
RAY H. STANGER | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1/17/81 | |
| 3. SEX Male | | | | | | | | | | 2b. HOUR 5:30 AM | |
| 4. RACE Caucasian | | | | | | | | | | 5. DATE OF BIRTH MONTH DAY YEAR
April 26, 1890 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | |
| 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Herbert Oliver Stanger | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Clara Nelson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 717-03-3053 | |
| 17. INFORMANT ADDRESS
Martha C. Browne, Same as 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Colon.
1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Due to, OR AS A CONSEQUENCE OF Urinary Tract Infection
(c) Due to, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Dis.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 MOS.
2 MOS.
10-15 YRS. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JUNE 19, 80, to 1/17, 19 81, that (I) (the) last saw the deceased alive on 1/17, 19 81, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN
Lawrence J. Thomas M.D. | | | | | | | | | | 22c. DATE SIGNED 1/17/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE J. THOMAS | | | | | | | | | | 22e. ADDRESS 11801 ROCKVILLE AVE, Rockville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | | | | | | | 23b. DATE 1981 January 18 | |
| 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Fairfax Virginia | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes P/A 300 W. Montgomery Ave., Rockville, Md. 20850 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 2 6 4 4 |
|---|--|---|--|---|--|---|---|--|---|------------------------------------|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
CHARLES John STAUBER | | | | | 2a. DATE OF DEATH
January 13, 1981 | | | 2b. HOUR
1:45 P.M. | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH Nov , DAY 19 , YEAR 1893 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
HERDSMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.D.A. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1608 Rainbow Drive | | |
| 14. FATHER'S NAME
FIRST Karl MIDDLE Staubert LAST Staubert | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Marie MIDDLE Effenberger LAST Effenberger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
216 46 3212 | | 17. INFORMANT
Carl M. Stauber | | | 16c. ADDRESS
1608 Rainbow Drive Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
4340
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
4 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Coronary artery disease | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/9 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/9 19 81 to 1/13 19 81 , that (I) (we) lost
saw the deceased alive on 1/13 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Reubenstein | | | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/13/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Reubenstein M.D. | | | | | 22e. ADDRESS
11161 New Hampshire Ave. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
1/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | 23d. LOCATION
CITY OR TOWN Brentwood , COUNTY P.G. STATE Md. | | |
| 24. FUNERAL DIRECTOR'S NAME
Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

Nov. 17/1915

Jan. 21/16

1915-16

1915-16

1915-16

1915-16

1915-16

1915-16

1915-16

1915-16

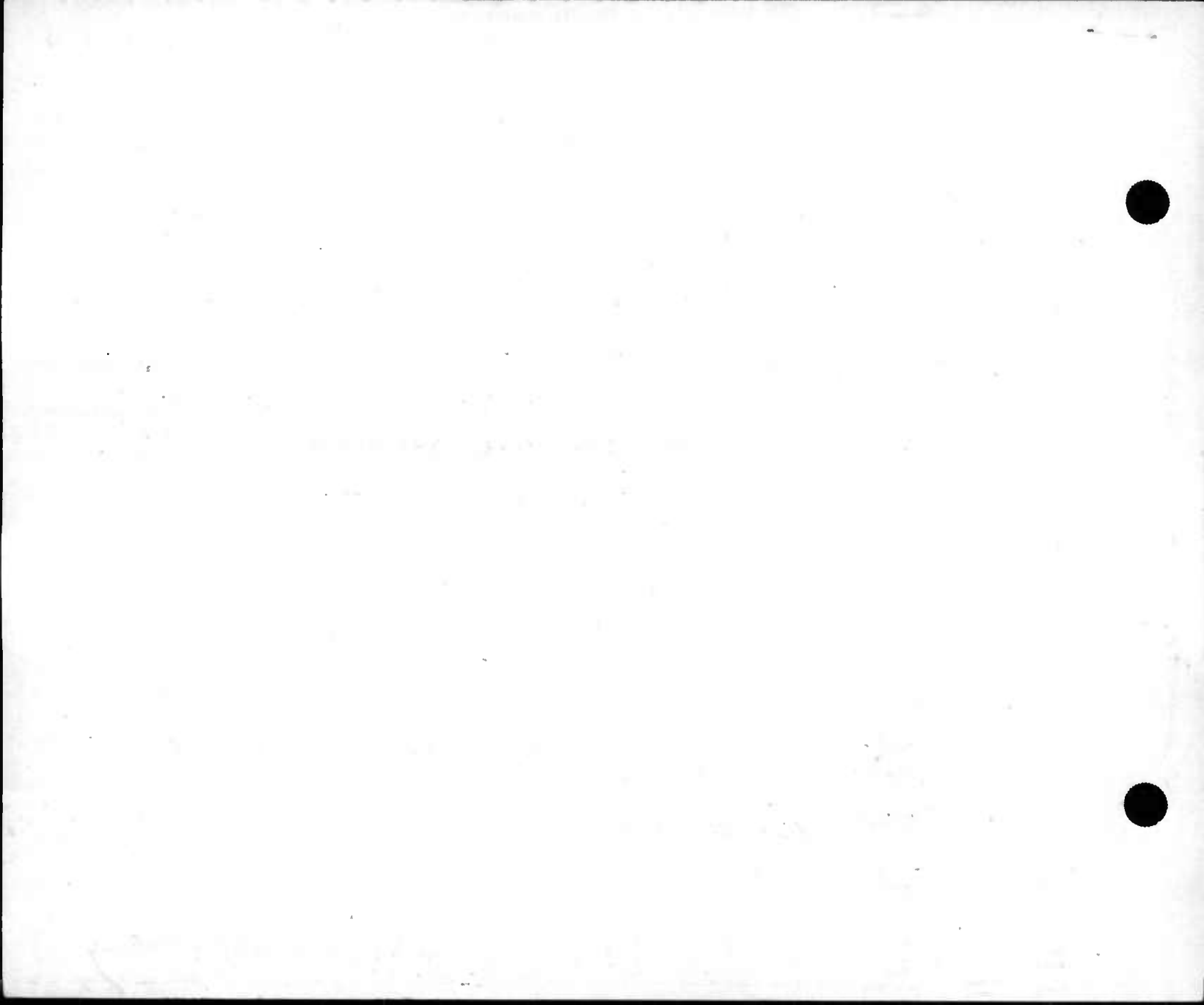
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 4 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HENRY W. STOEHRE | | | 2a. DATE OF DEATH MONTH DAY YEAR
1-7-81 | | 2b. HOUR
5:50 A.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
9 11 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
675 Thayer Avenue, #102 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Christian H. Stoehr | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary F. Foster | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-05-1119 | | 17. INFORMANT (wife) ADDRESS
Irma Karlyn Stoehr-(same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) HEPATO-RENAL SYNDROME
57L3
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) ALCOHOLIC LIVER DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 WKS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).
E. COLI SEPTICEMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15/80 to 1/7/81 , that (I) (we) last saw the deceased alive on 1/7/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Barry N. Rosenbaum, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/7/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY N. ROSENBAUM | | 22e. ADDRESS
3720 FARRAGUT AVE
KENSINGTON, MD 20795 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1-8-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Erner E. Pumphrey, Inc. | | ADDRESS
8434 Ga. Ave., S.S. MD | | 25a. DATE RECEIVED BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
Barry N. Rosenbaum | | | | | |



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 4 6

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bessie F. STONE | | | 2a. DATE OF DEATH
MONTH 1 DAY 23 YEAR 81 | | | 2b. HOUR
5 P.M. | |
| 3 SEX
F | | 4 RACE
CAUCASIAN | | 5 DATE OF BIRTH
MONTH 4 DAY 10 YEAR 91 | | 6 AGE (IN YEARS LAST BIRTHDAY)
90 YRS. 89 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LITHUANIA | | 7b. CITIZEN OF WHAT COUNTRY?
LITH. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY Co. MD. | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chevy Chase Conv. & Nurs. Ctr. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Grocer | | 12b. KIND OF BUSINESS OR INDUSTRY
Grocery | |
| 13a. STATE
MD | | | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
BETHESDA. | |
| 14 FATHER'S NAME
FIRST JACOB MIDDLE --- LAST FRAM | | | | 15 MOTHER'S MAIDEN NAME
FIRST --- MIDDLE --- LAST --- | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-56-1721 | | 17 INFORMANT
ADDRESS
HERBERT STONE 6011 SHADY OAK LA. BETHESDA MD | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular accidentAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 days**4360
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

Cerebral Arteriosclerosis Years

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
PARKINSONISM

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
--- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
--- P.M. --- 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
--- | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> - NOT WHILE <input type="checkbox"/> -
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
--- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
--- | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 19 60 to Jan 19 81 , that (I) (we) last
saw the deceased alive on 1-18-81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Arnold A. Lear MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/23/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARNOLD A. LEAR MD | | | | 22e. ADDRESS
3201 L ST. N.W. WASHINGTON DC 20037 | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1-25-81 | | 23c. NAME OF CEMETERY OR CREMATORY
KESHER ISRAEL CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
HARRISBURG PENN. | |
| 24. FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEM. CHAP. | | | | 25. DATE REC'D. BY REGISTRAR
JAN 28 1981 | | 25b. REGISTRAR'S SIGNATURE
Anthony McBrady | |

RECEIVED
JAN 10 1931

TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

DEAR MR. SPEAKER:

I have the honor to acknowledge the receipt of your letter of the 10th inst. regarding the proposed amendment to the National Firearms Act, 1934, and in reply to inform you that the same has been referred to the Committee on Education and Labor, and that the Committee is currently studying the same.

I am, Sir, very respectfully,
Yours truly,
J. P. [Signature]

(16)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked omitted, 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. Mayle, Dep. Medical Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8102647 | |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) KATHERINE Eicke STORY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/8/81 | | 2b. HOUR
1245 M. |
| 3. SEX
Female | 4. RACE
Cau. | 5. DATE OF BIRTH
MONTH DAY YEAR
May 2, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penn | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY
Masonic Temp |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
2106 Hildarose Drive | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Stanton | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen McAndrew | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
164-22-0536 | | 17. INFORMANT
ADDRESS
Richard R. Story same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-respiratory Arrest
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate
immediate
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Diabetes, Nephritis, Chronic Renal Failure | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 1980 , to 1/8 , 19 81 , that (I) (we) lost
saw the deceased alive on 1/7 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Joel Schuman | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/8/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joel Schuman | | 22e. ADDRESS
9410 Old Georgetown Rd Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-10-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Trinity Mem. Gardens | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Waldorf, Charles, Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Hunt Funeral Home, Waldorf, Maryland | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
Richard R. Story | | | |

100-1-10-01

100-1-10-01

x

U.S.A.

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

100-1-10-01

x

100-1-10-01

100-1-10-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 2 6 4 8 | |
|--|--|--|---|---|---|--|---|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>William Earle Sturges, Jr.</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
<i>Jan 13 1981 9:15 M</i> | | | | | | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Oct. 31, 1882</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>98</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Chevy Chase</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Apt. 1
3605 Chevy Chase Lake Drive</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>civil engr.</i> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
<i>3605 Chevy Chase Lake Drive</i> | | | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Chevy Chase</i> | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William Earle Sturgess, Sr.</i> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Gertrude Stott</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>---</i> | | 17. INFORMANT ADDRESS
<i>Bethesda, Md.
Carl R. Sturges 7714 Savannah Dr.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a). <i>Cardiac Failure</i>
4409
DUE TO, OR AS A CONSEQUENCE OF (b). <i>Arteriosclerosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c).
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Pneumonia</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/13</i> 19 <i>81</i> to <i>present</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/13</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John B. Umhau</i> MD | | | | | DEGREE
<i>MD</i> | | | 22c. DATE SIGNED
<i>1/13/81</i> | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>John B. Umhau</i> | | | | | 22f. ADDRESS
<i>8805 Conn. Ave., Chevy Chase Md</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1/15/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Memorial Park</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Rockville, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 19 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

26

1

73

27

35

50

1

1

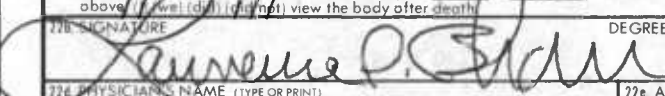

5

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 2 6 4 9 | |
|---|--|---|--|---|--|---|--|---|----------------------------|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Ölin Earl TEAGUE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 23 1981 | | | 2b. HOUR
6:20A M | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
April 6, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
70 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Congressman | | 12b. KIND OF BUSINESS OR INDUSTRY
Government | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wood Acres | | 13e. STREET ADDRESS
6015 Massachusetts Ave. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James Martin Teague | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ida Sturgeon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
John O. Teague, Rt.5, Box 1332, College Sta., | | ADDRESS
Texas | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic renal failure with serosanguineous pericarditis
2500 } DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes Mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 15 , 19 81 , to Jan. 23 , 19 81 , that I (we) lost saw the deceased alive on Jan. 23 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (do) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 23, 1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lawrenc D. Bohan, M.D. | | | | | | 22e. ADDRESS
National Naval Medical Center, Bethesda, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler Sons, Inc. ADDRESS Washington, D.C.
5130 Wisconsin Avenue, N.W. | | | | | | 25a. DATE REC'D. BY REGISTRAR
Jan 28 1981 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

presented in the following table:

279

1000

222

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

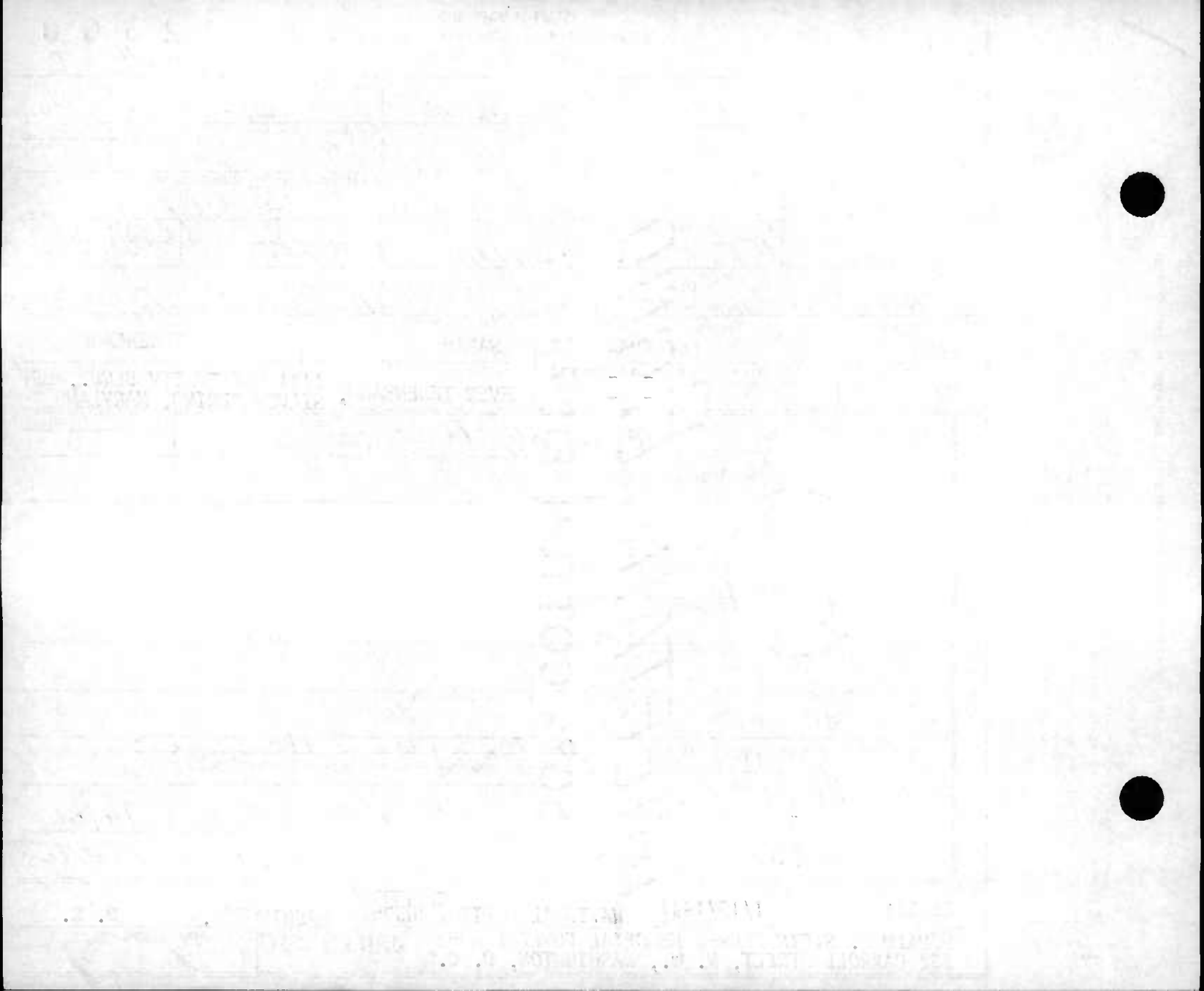
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 5 0
REG. NO. 4-24240-0

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
PESA TENENBAUM | | | 2a. DATE OF DEATH MONTH DAY YEAR
01-14-81 | | 2b. HOUR
8:07 AM |
| 3. SEX
FEMALE | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
05-05-09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | 7b. CITIZEN OF WHAT COUNTRY?
POLAND | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
MARYLAND Montgomery Silver Spring | | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
1121 University Blvd #208 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ELLA LEDERMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
SARAH TENENBAUM | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 17. INFORMANT ADDRESS
MEYER TENENBAUM, 1121 UNIVERSITY BLVD. WEST SILVER SPRING, MARYLAND | | | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) 2030
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | |
| 19a. DATE OF OPERATION
2 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
9 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
11:45 P.M. 12 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
X | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
X | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
X | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-29 , 19 81 , to 1/14 , 19 82 , that (I) (we) lost saw the deceased live on above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Raymond Bass | | | | 22c. DATE SIGNED
1/18/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | | | 22e. ADDRESS
16220 Frederick Ave Gaithersburg | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
1/15/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL CAPITOL HEBREW CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
WASHINGTON, D. C. | | 23e. NAME OF FUNERAL HOME
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | 23f. ADDRESS
232 CARROLL STREET, N. W., WASHINGTON, D. C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
DONALD M. STEIN | | 25a. DECEASED'S SIGNATURE
JAN 15 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal case must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 5 1

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
Ralph D. Tennis | | MONTH DAY YEAR
1 23 81 | | 2330 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| male | Caucasian | MONTH DAY YEAR
5 31 98 | 82 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| (STATE OR FOREIGN COUNTRY)
Mich. | USA | <input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | Shady Grove Adventist Hosp. | (TYPE OF WORK FOR MOST OF WORKING LIFE)
OPTICIAN | SELF-EMPLOYED | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | Montg. | Gaithersburg | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 811 S. FREDERICK AVE. | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| FIRST MIDDLE LAST
RALPH TENNIS | FIRST MIDDLE LAST
KATHERINE BAUMAN | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WWI | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| 577-48-2043 | | HARRIET K TENNIS SAME AS # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardiorespiratory arrest | | | | | 4 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis | | | | | 17 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis | | | | | 5 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Hypertension, Diabetes mellitus, Coronary artery disease | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from Jan 6 19 81 to Jan 23 19 81, that (we) lost the deceased alive on Jan 23 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | | | |
| (TYPE OR PRINT) | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 1-24-81 | | | |
| 22d. PHYSICIAN'S NAME | 22e. ADDRESS | | | | |
| James R. Moore Jr. MD | 207 Brookes Ave Gaithersburg Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| BURIAL | 1-27-81 | PARKLAWN CEMETERY | CITY OR TOWN | COUNTY | STATE |
| | | | Rockville | Montg. | Md. |
| 24. FUNERAL DIRECTOR | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS
DeVol Funeral Home WASH. D.C. | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 1 0 2 6 5 2 | | REG. NO. | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Jeanette NMN. Thomas</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1 13 81</i> | | 2b. HOUR
<i>12⁵⁵ AM</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>4 3 07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
<i>73</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
<i>md.</i> | | 13b. COUNTY
<i>MO.</i> | |
| 13c. CITY OR TOWN
<i>Sandy Spring</i> | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>18565 Brook Road</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Thomas Walker</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Mary Bonds</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>579-42-8034</i> | | 17. INFORMANT ADDRESS
<i>Richard Thomas WASH. D.C. 1450 Irving St., N.W.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>aspiration pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>myelodysplasia (cardio) sclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Approximate interval between onset and death: <i>2 days</i>
<i>10 months</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>PM 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 31, 1980</i> , to <i>1-13, 1981</i> , that (I) (we) last saw the deceased alive on <i>1-12, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>John Kijak Jr.</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1-13-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JOHN KIJAK, Jr., M.D.</i> | | | | 22e. ADDRESS
<i>Washington Adventist Hosp. Takoma Park</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>1-19-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ash, Mem. Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Sandy Spring Montg Md.</i> | |
| 24. FUNERAL DIRECTOR NAME
<i>George R. Snowden</i> | | | | 24b. ADDRESS
<i>246 N. WASH. ST. Rockville, MD. 20850</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 16 1981</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | |

Handwritten text, possibly a name or date.

1950 June 21

ST-42-200 Richard Thomas

Handwritten notes, possibly a list or description.

Handwritten text, possibly a date or reference.

1981

THOMAS, K. J. / K. J. Washington
1-19-81 Ash Hill, Conn. Sample 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

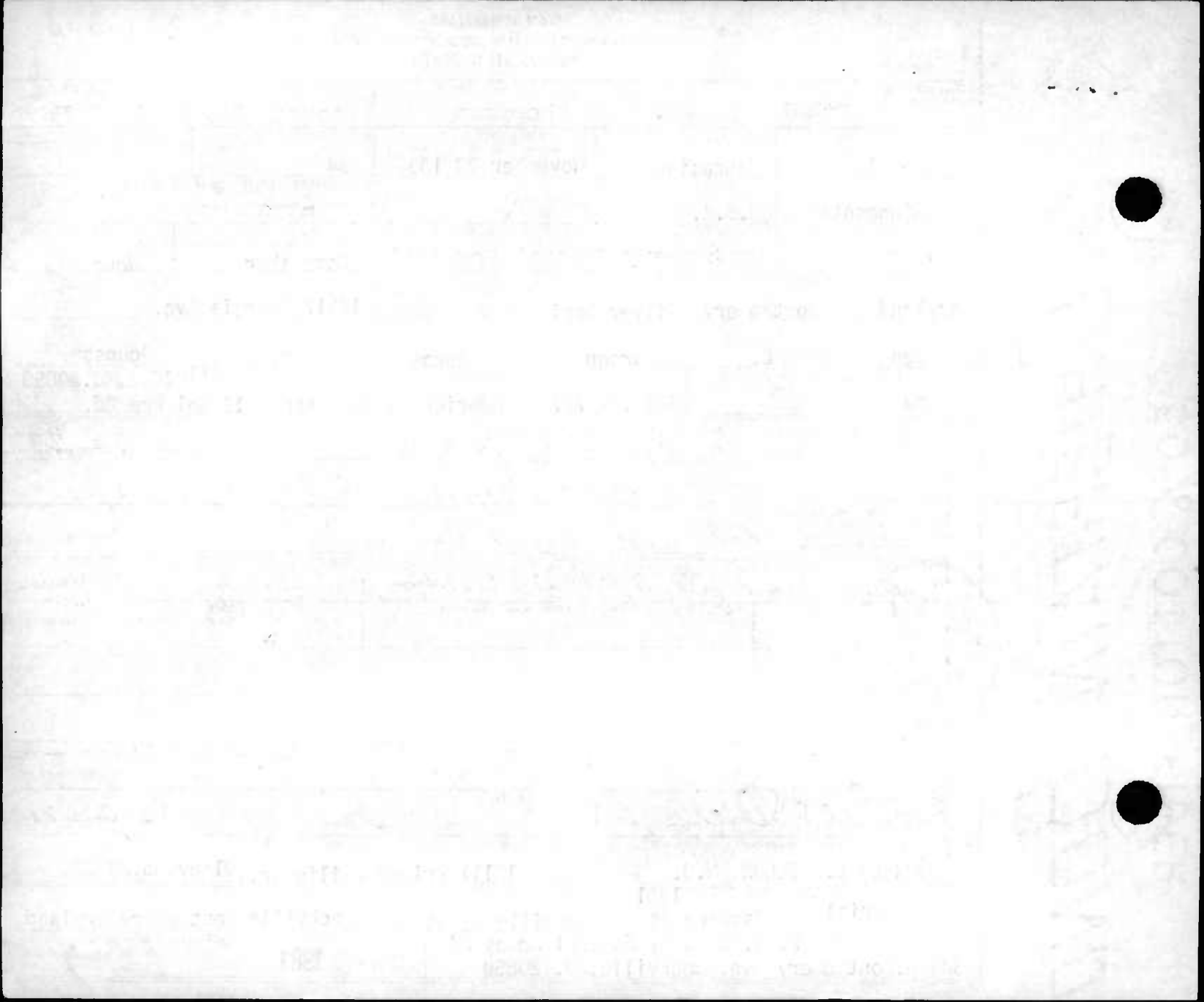
Handwritten text at the bottom of the page, possibly a signature or date.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ethel M. Thompson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 21, 1981 | | 2b. HOUR
6:57AM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
November 23 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ben E. Larson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna C. Johnson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
469-14-4727 | | 17. INFORMANT
Roderick L. Thompson ADDRESS Rockville, Md. 20853 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
1749
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Metastatic cancer both lungs + pleura
DUE TO, OR AS A CONSEQUENCE OF:
(c) Left Breast Cancer | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
2 yrs.
3 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Congestive heart failure, atrial fibrillation, cardiomegaly, pleural effusion | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 Jan 81 to 21 Jan 81 , that (I) (we) last saw the deceased alive on 20 Jan 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Donald E. Dillon MD | | | DEGREE | | 22c. DATE SIGNED
21 Jan 81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD E. DILLON, M.D. | | | 22e. ADDRESS
18111 Prince Philip Dr., Olney, Md. 20832 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
January 24 | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Maryland |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | ADDRESS
Funeral Homes P/A 300 W. Montgomery Ave., Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
JAN 29 1981 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102654

| | | | |
|--|---|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Naim</u> MIDDLE <u>THOMPSON</u> LAST <u>THOMPSON</u> | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>1-24-81</u> | |
| 3. SEX
<u>Male</u> | 4. RACE
<u>Black</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>1 24 81</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<u>1hr</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>MONTGOMERY Co.</u> MD. |
| 10. CITY OR TOWN OF DEATH
<u>SIL. SPR.</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>HOLY CROSS HOSPITAL</u> | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>none</u> | 12b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY OR TOWN <u>Silver Spring</u> | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS
<u>1966 Rosemary Hill Drive</u> |
| 14. FATHER'S NAME
FIRST <u>LASUN</u> MIDDLE <u>S.</u> LAST <u>ATOLAGBE</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>DESIREE</u> MIDDLE <u>THOMPSON</u> LAST <u>THOMPSON</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>no</u> | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>none</u> | 17. INFORMANT
ADDRESS
<u>Lasun Atolagbe same as 13c</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>7651</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Penetrating Wound</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Penetrating Wound</u> | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-24-81</u> 19 <u>81</u> , to <u>1-24-81</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>19</u> <u>1-24-81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Eugene Sussman, M.D.</u> | 22c. DEGREE
<u>MD.</u> | 22d. DATE SIGNED
<u>1/24/81</u> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Eugene Sussman, M.D.</u> | 22f. ADDRESS
<u>2401 Phlox Drive, Overland Park, Mo.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | 23b. DATE
<u>1/27/81</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery Silver Spring, Maryland</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
<u>Tyson Wheeler Funeral Home, Inc.</u>
<u>1331 Rockville Pike Rockville, Maryland</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 28 1981</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

James A. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 02655

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William C Thompson | | | 2a. DATE OF DEATH
MONTH 1 DAY 2 YEAR 81 | | 2b. HOUR
12:15 P |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH 6 DAY 15 YEAR 1902 | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | IF UNDER 1 YEAR
MONTHS 78 DAYS 78 HOURS 78 MIN. 78 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
United Staes | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Builder | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Chevy Chase | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
8914 Clifford Avenue | |
| 14. FATHER'S NAME
FIRST William MIDDLE C LAST Thompson | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Hollock LAST Hollock | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
578 10 4707 | | 17. INFORMANT ADDRESS
Emma G. Thompson same as item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Glushtatoma Multiformis
1919
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (was did) attended the deceased from 15 Dec 80 to 2 Jan 81 , that (I) (was did) saw the deceased alive on 28 Dec 80 , and that in (my) (was did) opinion death occurred on the date and hour and from the causes stated above, (I) (was did) viewed the body after death. | | | | | |
| 22b. SIGNATURE
Walter E. Goetz MD | | DEGREE
MD | | 22c. DATE SIGNED
2/JAN/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOZT MD | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Jan 5, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
Suitland, Maryland | | STATE MD | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 6 5 6 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR
Georgena | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Georgena M. Thomson | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Jan. 15 1981 | | | |
| 3 SEX
Female | | | | 2b. HOUR
9 ¹⁵ AM | | | |
| 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Aug. 2, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2414 Sun Valley Circle | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Hair dresser | | 12b. KIND OF BUSINESS OR INDUSTRY
Beauty Shop | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY
Montgomery | | | |
| 13c. CITY OR TOWN
Sil. Sp. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS
2414 Sun Valley Circle | | | | 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Collings | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Small | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
No None | | | |
| 16b. SOCIAL SECURITY NO.
027-20-1085 | | | | 17. INFORMANT
Sliver Spring, Md.
Warren Thomson-son 2414 Sun Valley Circle | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
4140
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<u>Diabetes Mellitus</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
— | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1976</u> to <u>present</u> , 19 <u>81</u> , that (I) (we) lost <u>the deceased</u> on <u>1/4</u> 19 <u>81</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John B. Umhau MD</u> | | | | DEGREE
MD | | 22c. DATE SIGNED
1/15/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Umhau | | | | 22e. ADDRESS
8805 Conn. Ave. Chevy Chase, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1-16-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. 20002 | |
| 24. FUNERAL DIRECTOR NAME
Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002 | | | | 25. DATE REC'D. BY REGISTRAR
JAN 22 1981 | | | |
| 26. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | |

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

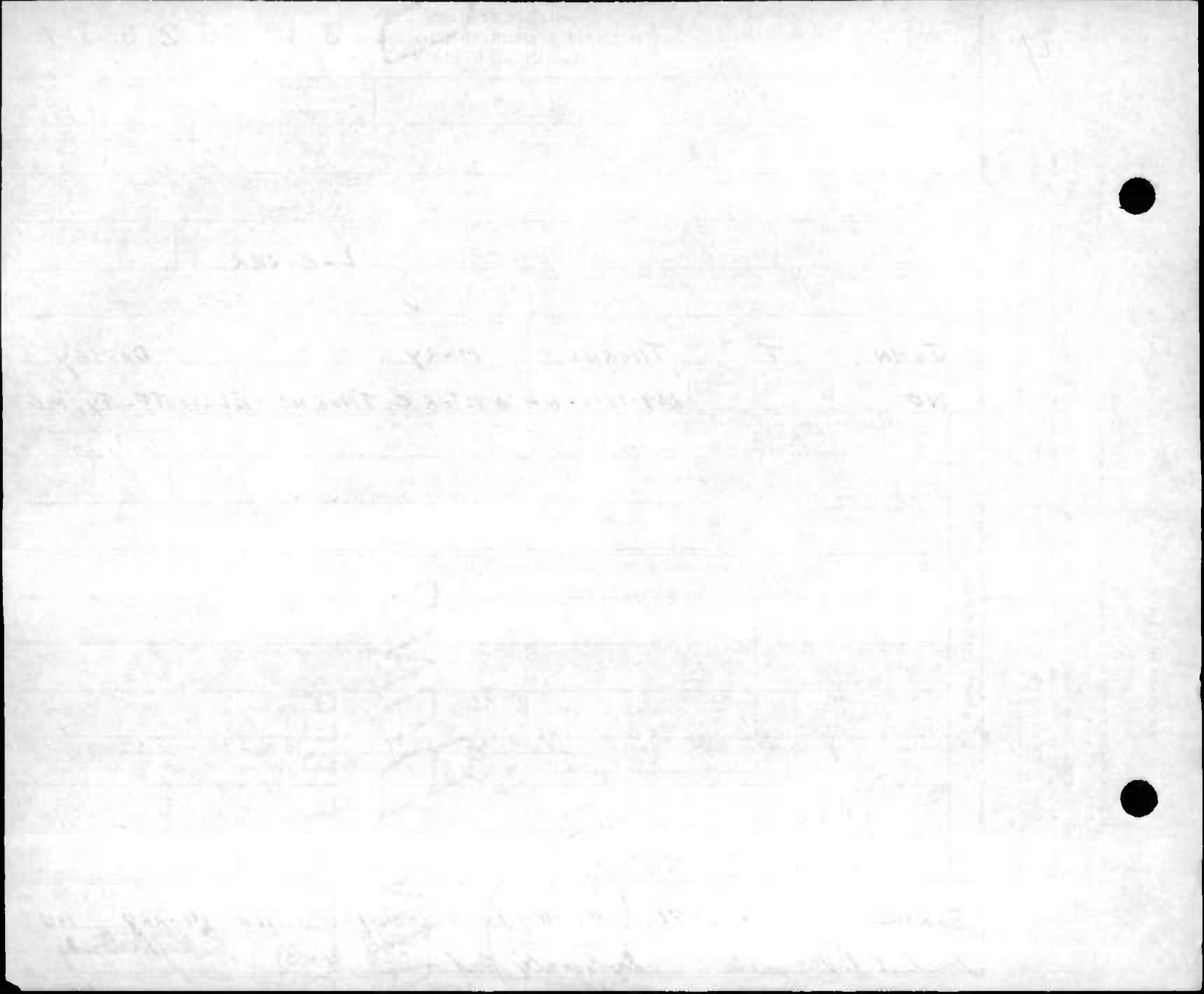
REG. NO.

| | | | | | | | |
|---|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
John R. Thorns | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 29, 1981 | | 2b. HOUR
1:15 PM | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 - 1 - 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83
YRS. MONTHS DAYS
IF UNDER 1 YEAR
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. CITY OR TOWN
Howard | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
14898 Bushey Park Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN T. THORNS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY DERSEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-18-8610A | | 17. INFORMANT
WALTER C. THORNS ADDRESS
ELLICOTT CITY, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) dehydration
2765 DUE TO, OR AS A CONSEQUENCE OF:
(b) organic brain syndrome
DUE TO, OR AS A CONSEQUENCE OF:
(c) aspiration pneumonia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
Nov 30, 1980 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
aspiration pneumonia | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11:00 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Nov 30, 1980 to Jan 29, 1981 , that (1) we lost
saw the deceased alive on Jan 28, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
obvious (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark S. Rosen MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/29/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark S. Rosen | | | | 22e. ADDRESS
Silver Spring, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-3-81 | | 23c. NAME OF CEMETERY OR CREMATORY
BUSHEY PARK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
COCKSVILLE HOWARD MD | |
| 24. FUNERAL DIRECTOR
NAME
Michael P. Margulies | | | | ADDRESS
Sykesville, Md | | 25a. DATE REC'D. BY REGISTRAR
FEB 2 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examination should be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the Bureau after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

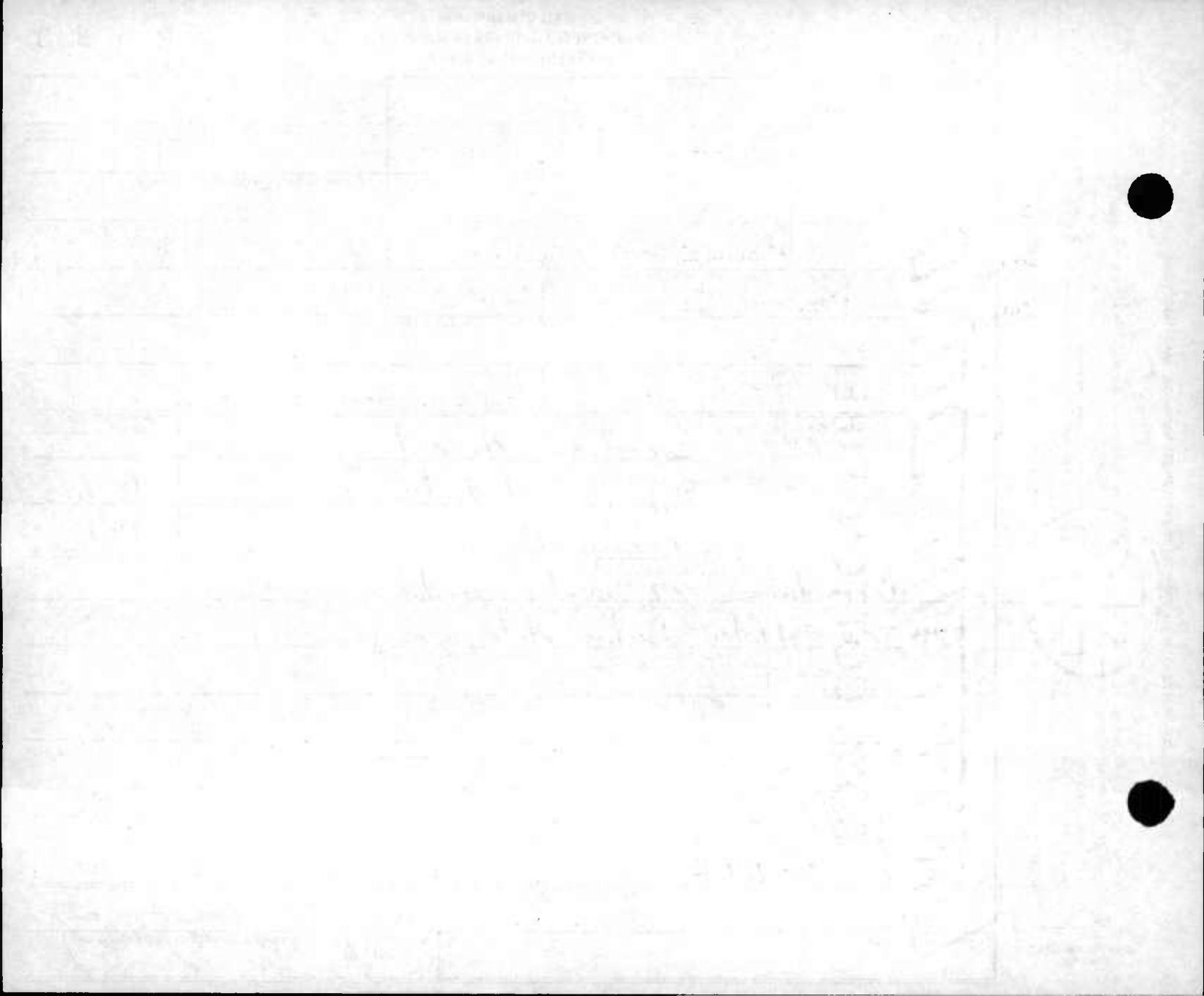
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 5 8

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|--|---|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Douglas Michael TIMM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 24 1981 | | 2b. HOUR
7:12P ^M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 15 1981 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
9 | | 7. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Naval Medical Center | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS
38 Oak Street | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gerald W. TIMM | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Yvonne M. Boomer | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
N/A | | |
| 17. INFORMANT
ADDRESS
Yvonne M. Boomer See item 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac Arrest</u>
7470
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypoxia and Acidosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pneumothorax</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 hrs
18 hrs | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Premature 27 weeks Gestation</u> | | |
| 19a. DATE OF OPERATION
23 JAN 1981 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Patent Ductus Arteriosus</u> | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15</u> , 19 <u>81</u> , to <u>Jan. 24</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 24</u> , 19 <u>81</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>J H NADING</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
Jan. 29, 1981 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>J H NADING</u> | | 22e. ADDRESS
National Naval Medical Center, Bethesda, M.D. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
National Naval Medical Center | | |
| 24. FUNERAL DIRECTOR
NAME | | 24b. ADDRESS | | 25a. DECEASED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 2 1981 | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 5 9

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Irene Price Tolbert</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>1 25 81</u> | | | 2b. HOUR
<u>3 15</u> M | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>2 5 1925</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>55</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Suburban Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | |
| 13a. STATE
<u>MD</u> | | | | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Rockville</u> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Robert Cecil Price</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Lucy Margaret Caldwell</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>224024-1551</u> | | 17. INFORMANT
<u>David T. Tolbert</u> | | | Same as item 13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
<u>1749</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>METASTATIC BREAST CANCER, EXTENSIVE 15 YEARS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>MINUTES</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 <u>81</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> 19 <u>81</u> , to <u>1/25</u> 19 <u>81</u> , that (I) (we) (lost) saw the deceased alive on <u>1/24</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Edward Mehlman</u> , M.D., F.C.C.P. | | | DEGREE <u>FOR DR. STEPHEN NEWMAN</u>
ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED:
<u>1/25/81</u> | | |
| 22d. PHYSICIAN'S NAME (NAME OR PRINT)
<u>Edward Mehlman, M.D.</u> | | | 22e. ADDRESS
<u>5625 Bradley Blvd. Bethesda, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | | 23b. DATE
<u>1/28/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Mem. Park</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Rockville Montgomery Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Tyson Wheeler Funeral Home, Inc.</u> | | | 25a. DATE RECD. BY TELE. RAR. 25b. REGISTRAR'S SIGNATURE
<u>JAN 28 1981</u> | | | | | | |
| 1331 Rockville Pike Rockville, Maryland | | | | | | | | | |

(M)

1931 Rockville Pike, Rockville, Maryland
Lynch & Co. Inc.
Lynch & Co. Inc.
Lynch & Co. Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Denny C. Tomlinson | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-28-81 | | | | | 2b. HOUR
9:40 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 27, 1892 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self Employed | | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | 16. STREET ADDRESS
301 Russell Avenue | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
WW I | | 17. INFORMANT
Pete V. Treibley, Washington, D.C. | | | 17a. ADDRESS
6517 Barnaby St., NW | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Terminal Respiratory failure</u>
7991
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1/20/81 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1980</u> , 19____, to <u>1/28/81</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/27/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/28/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
OSOOTH LEKAGUL MD | | | | | 22e. ADDRESS
7425 Arlington Rd Bethesda Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | | 23b. DATE
1/31/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc. | | | | | ADDRESS
5130 Wisconsin Ave., NW, Washington, D.C. | | | 25. REGISTERED BURIAL DIRECTOR'S SIGNATURE
 | | | |

Tomlinson, C. J. 1991

White April 17, 1992 88

all related 1992

Montgomery Gaithersburg 301 Russell Avenue

Unknown

Unknown

5117 S. 1st St., N.E.

220-40-6601 v. Trebley, Washington, D.C.

Yes

Montgomery, Maryland

1991 1991

Joseph G. Galt, Inc.

2130 Wisconsin Ave., N.W., Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 6 1

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PALMER LEONARD TOMLINSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 4, 1981 | | 2b. HOUR
7:30 A.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 20, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER, BETHESDA, MD. NIH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Miner | | 12b. KIND OF BUSINESS OR INDUSTRY
Mining | |
| 13a. STATE
VIRGINIA | | 13b. CITY
Tazewell | | 13c. CITY OR TOWN
BLUEFIELD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
J. W. Tomlinson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cretia Williams | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 230-01-6352 | |
| 17. INFORMANT
ADDRESS
MRS. VERA TOMLINSON, WIFE (SAME AS ABOVE) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEVERE INTERSTITIAL PNEUMONITIS
5168
DUE TO, OR AS A CONSEQUENCE OF
(b) SEVERE CORONARY ARTERIOSCLEROSIS, STATUS
POST CHEMOTHERAPY FOR DIFFUSE HISTIOCYTIC LYMPHOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) DIFFUSE HISTIOCYTIC LYMPHOMA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
7 YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
QUESTIONABLE SEPSIS WITH SPLENITIS
7 YEARS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from DECEMBER 30, 1980, to JANUARY 4, 1981, that (X) (we) lost
saw the deceased alive on JANUARY 4, 1981, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated
above, (X) (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Margaret Parker MD | | | | DEGREE
MD | | 22c. DATE SIGNED
1/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Margaret Parker MD | | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD. 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
January 7 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
P. H. H. H. | |

BP



1981
October 1st
1981

1981

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If there is a traumatic event, the medical examiner must be notified at once.

RELEASED BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8102662 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Harriet L. Townley | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 29/ 81 | | 2b. HOUR
1:00 p.m. | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
March 7, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY
Dental | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Malcolm McKenzie | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lucy Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
364-14-3837 | | 17. INFORMANT ADDRESS
William Zinnbauer 4642 West Dr. Ft. Myers, Florida | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic aneurysm Sudden
4413
DUE TO, OR AS A CONSEQUENCE OF (b) aortic atherosclerosis
10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
none | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
12/29 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/29 1980 to 12/31 1980 that (I) (we) last saw the deceased alive on 12-30 1980 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
STEPHEN W. DEJTER, M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-29-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN W. DEJTER, M.D. | | | | 22e. ADDRESS
6719 WILSON LANE, BETHESDA, MD 20834 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
February 2, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory, Alexandria, Virginia | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



RECEIVED BY WELLS FARGO BANK

FEB 2 1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 6 3

1 - FOR
STATE
REGISTRAR

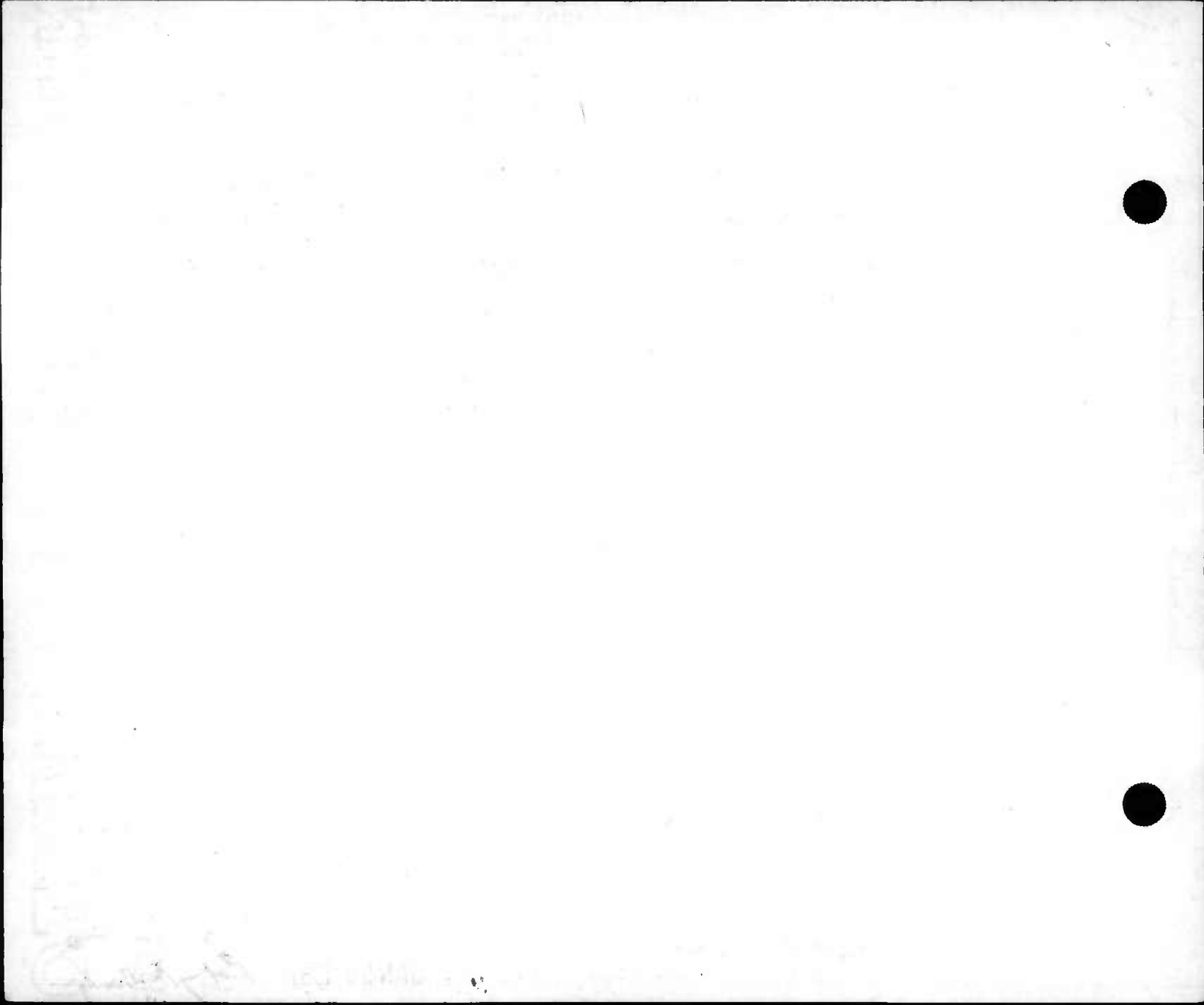
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) NEVILLE J. Townsley | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 25 81 | | 2b. HOUR
11:40 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 15 21 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
59 | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chief Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Garfinckls |
| 13a. STATE
Md. | | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Sil. Spr. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Neville Townsley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Cosi | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 577-38-8366 | | 17. INFORMANT
ADDRESS
Loretta H. Townsley Same as 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of sigmoid metastatic
1533
DUE TO, OR AS A CONSEQUENCE OF
(b) Dehydration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) malnutrition | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1478 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Anemia | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-25-81 19 78 , to 1-25-81 19 81 , that (I) (was) lost saw the deceased alive on 1-25-81 19 81 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J B Patnick III MD | | | DEGREE
MD | | 22c. DATE SIGNED
1-26-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G B Pottrick III MD | | | 22e. ADDRESS
9221 Colesville Rd Silver Spring, Md. 20910 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/29/81 | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery Brentwood, Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Md. |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Pumphrey, Inc. | | ADDRESS
Sil. Spr., Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | 25b. REGISTRAR'S SIGNATURE
Pumphrey |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|---------|---|---|
| 1. FOR STATE REGISTRAR | | 8 1 0 2 6 6 4 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | |
| FIRST MIDDLE LAST
WILLMER L. TRAGESER | | MONTH DAY YEAR
JAN 1, 1981 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) |
| MALE | WHITE | JANUARY 15 1931 | 49 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| MARYLAND | | USA | |
| 10. CITY OR TOWN OF DEATH | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| SILVER SPRING | | MONTGOMERY MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| HOLY CROSS MARYLAND HOSPITAL, S S | | Fed. Gov. Computer | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN |
| MD | | MONTGOMERY | SILVER SPRING |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST
John H. Trageser | | FIRST MIDDLE LAST
Grace E. Pierce | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Yes | | 219-36-9348 | |
| 17. INFORMANT | | ADDRESS | |
| Joan M. Trageser (same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| SWEEPING SIDEWALK SNOW. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| | | | |
| 20. AUTOPSY? | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 1 1 1981 | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| | | Home | |
| 21f. LOCATION | | 21g. LOCATION | |
| STREET CITY OR TOWN COUNTY STATE | | STREET CITY OR TOWN COUNTY STATE | |
| 126 LYNNMOR DR SILVER SPRING MONT MD | | 126 LYNNMOR DR SILVER SPRING MONT MD | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | |
| TITLE (SPECIFY) | | | |
| M.D. Dept | | | |
| ACTUAL SIGNATURE | | DATE SIGNED | |
| Francis C. Mayke Jr | | 11/18/81 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | |
| Francis C. Mayke Jr | | 8200 Wisconsin Ave Bethesda MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| CREMATION | | JAN. 2. 1981 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Fair Lakes Cemetery | | Baltimore, MD | |
| 24. FUNERAL DIRECTOR | | DATE OF REGISTRATION | |
| Takoma Funeral Home, 254 Canal St Np | | JAN 5 1981 | |

RECEIVED

NOV 11 1961

AMERICAN AIR FORCE

NOV 11 1961

SILVER STAR MEDAL FOR MERITORIOUS SERVICE

FOR THE DISTRICT OF COLUMBIA

MONTGOMERY

SILVER STAR

FOR THE DISTRICT OF COLUMBIA

John W. Thompson

Grace E. Brown

John W. Thompson (as 1961)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 6 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) NELLIE (Helen) TROTMAN | | | 2a. DATE OF DEATH
MONTH 1 DAY 17 YEAR 81 | | | 2b. HOUR
10:55 PM | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 02 DAY 01 YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
England | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Joe MIDDLE Broadbent LAST Broadbent | | 15. MOTHER'S MAIDEN NAME
FIRST Ellen MIDDLE Burton LAST Burton | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
577-94-2469 | | 17. INFORMANT
ADDRESS Barbara H. Haynes, Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE CEREBROVASCULAR ACCIDENT
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ARTERIOSCLEROTIC HEART DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1976 , to JAN 17 1981 , that (I) (we) lost
saw the deceased alive on JAN 17 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R.C. Paddario MD | | | | DEGREE
MD | | 22c. DATE SIGNED
1-17-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT C. PADDARIO | | | | 22e. ADDRESS
5413 CEDAR LANE BETHESDA MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | 23b. DATE
Jan. 19, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Cren. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Barbara H. Haynes</i> | |

W/277110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 6 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANASTASIA | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 1-8-81 | | | | 2b. HOUR ^a
11:10 ^M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR January 1, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Bulgaria | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7017 Richard Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Kotzjohn | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria (Unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
389-03-45320 | | 17. INFORMANT
ADDRESS
Sally Peavy Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic Heart Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
Months
Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Cerebral Colon | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1980 to 1/8 1981 , that (I) (we) lost saw the deceased alive on 1/8 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Joel Schuman | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/8/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joel Schuman | | | | 22e. ADDRESS
9410 01d Georgetown Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(RECEIVED)
Burial | | | | 23b. DATE
January 13 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Albuquerque, New Mexico | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | ADDRESS
Homes, P.A. Bethesda, Maryland | | 25a. DATE REC'D BY REGISTRAR
JAN 14 1981 | | 25b. SIGNATURE
[Signature] | |

UNITED STATES GOVERNMENT
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D. C. 20503

MEMORANDUM FOR THE DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

SUBJECT: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

[Handwritten signature]

JAN 1 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 6 7

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY Virginia TURNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-11-81 | | | 2b. HOUR
5:45 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 25 31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina, US | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont CO MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Government | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
13024 Tamarack Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Lytle | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Lytle | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
258-42-1440 | | 17. INFORMANT
ADDRESS
Patient's medical record | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
2030
DUE TO, OR AS A CONSEQUENCE OF
(b) Angioidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Multiple Myeloma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
3 years
3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Right frontal lobe meningioma | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1975 , 19____, to 1/11/81 , 19____, that (I) (we) last saw the deceased alive on 1/11/81 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
covering for Dr. Nicholas Rogentine | | | | | | | | | | |
| 22b. SIGNATURE
Wesley B. Mason MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
1/11/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wesley B. Mason | | | | | | 22e. ADDRESS
10500 Summit Ave, Kensington, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
1-15-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Church | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ashville SC | | |
| 24. FUNERAL DIRECTOR
NAME
Hudleys | | | ADDRESS
1425 MD AVE NE WASH., D.C. | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE
L. J. H. H. H. | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEDICAL CERTIFICATION

10

35

50

1

2

9

1

1402

BP

PH 16 2 0 1041 31M47

1000

1000



1-10-01 1041 31M47
1000 1000 1000

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 6 8

REG. NO.

| | | | | | |
|---|---------------------|--|---|---|---------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) ETHEL M. TYLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/20/81 | | 2b. HOUR
6:18 M |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
01 20 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 - 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO., MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner Ceramic Shop | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Hyattsville | | 13c. STREET ADDRESS
5408 20th Pl | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George E. Montgomery | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Day | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
577-38-7310 | | 17. INFORMANT
James F. Tyler (Husband) | | 17. ADDRESS
Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous Cell Carcinoma
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) Right Lung with metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Bronchitis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19, 1981 to Jan 20, 1981 , that (I) (we) lost
saw the deceased alive on Jan 19, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard P. Whelton | | 22c. ADDRESS
7100 Baltimore Ave College Park | | 22d. DATE SIGNED
Jan 20, 1981 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD L. WHELTON | | 22f. ADDRESS
7100 Baltimore Ave College Park | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-23-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veterans Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY
Cheltenham Pr. Geo. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. Mt. Rainier, Md. | | 25b. REGISTRAR'S SIGNATURE
History McBrady | | | |

MEDICAL CERTIFICATION

47
68
35
164
2
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102669

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|---|-------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary Margaret Usilton | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 30 81 | | 2b. HOUR 5:45 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman M. Wilson | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Gaithersburg | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS 8 Crown Court | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James E. O'Neill | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Rebecca HODGEKINS | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO 220-28-6249 17. INFORMANT daughter ADDRESS Johann U. Tyler same as 13 | |

| | | | |
|--|---|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
4279 IMMEDIATE CAUSE (a) Cardiac Dysrhythmia, Suspected
DUE TO, OR AS A CONSEQUENCE OF Atrial
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Emphysema
DUE TO, OR AS A CONSEQUENCE OF and
(c) Chronic Bronchitis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute
year
year | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Respiratory Failure; Right Pneumectomy | | | |
| 19a. DATE OF OPERATION 1/22 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Pneumectomy | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 78 to Jan 30 , 19 81 , that (I) (we) last saw the deceased alive on Jan 23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | |
| 22b. SIGNATURE G. Stuart Scott M.D. DEGREE | | 22c. DATE SIGNED 1/30/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Stuart Scott, M.D. | | 22e. ADDRESS 19201 Montgomery Village Ave. Gaithersburg | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Feb. 2, 1981 | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md. |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1981 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

81-02670

| | | | | | | | | | | | |
|--|--|---|--|---|---------------------|---|--|--|--|---------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
SADIE VEDERMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 15, 1981 | | 2b. HOUR
5:55 AM | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
SEPTEMBER 14, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
81 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)
POTOMAC VALLEY NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESLADY | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
PENNSYLVANIA | | 13b. COUNTY
PHILADELPHIA | | 13c. CITY OR TOWN
PHILADELPHIA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6924 LARGE STREET | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JACOB MILLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MINNIE (UNASCERTAINABLE) | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO
166-28-6875A | | 12. INFORMANT
MINNIE SCHECHTER, | | ADDRESS BETHESDA, MARYLAND
6209 PLAINVIEW ROAD, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>
4292 DUE TO, OR AS A CONSEQUENCE OF
b) <i>Coronary artery disease</i>
10 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Sudden</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/6/78, 19 to 1/15, 1981, that (I) (we) last saw the deceased alive on 1/15, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin MD | | | | DEGREE | | | | BY DATE SIGNED
1/15/81 | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN | | | | 22d. ADDRESS
2309 SHOREFIELD RD
WHEATON MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/18/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
ROOSEVELT MEMORIAL PARK | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BUCKS COUNTY, PA. | | | |
| 24. FUNERAL DIRECTOR
DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25a. D. J. FILED BY REGISTRAR
JAN 18 1981 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

0 3 8 0

6

CONFIDENTIAL

THREAT

MAY 1974

CONTINUED

WETA

CONFIDENTIAL

CONFIDENTIAL

WETA

CONFIDENTIAL

CONFIDENTIAL

WHITE

WHITE

CONFIDENTIAL

WHITE

WHITE

WHITE

WHITE

1/4/77

CONFIDENTIAL

WHITE

WHITE

WHITE

TO MEDICAL EXAMINER: THIS CERTIFICATE MUST BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 18 G552 2/24/81 dad

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 0 2 6 7 1

| | | | | | | | | |
|--|------------------|---|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MATTHEW J. VEENSTRA | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
1-28 1981 | | | 2b. HOUR
M
P
M | | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 11 1980 | 6. AGE (IN YEARS)
LAST BIRTHDAY
YRS. MONTHS DAYS
5 17 | IF UNDER 1 YR.
MONTHS DAYS
5 17 | IF UNDER 24 HRS.
HOURS MIN.
17 | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
1-28 1981 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
11812 Mentone Rd. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Diane Viverette | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | |
| 16b. SOCIAL SECURITY NO.
none | | | 17. INFORMANT
ADDRESS
Rick Veenstra 12105 Amblerwood Dr., Laurel, Md. 20811 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
- Sudden Infant Death Syndrome Bronchiolitis
5188 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell, M.D. | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | DATE SIGNED
1-29-81 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1981
January 31 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | ADDRESS
300 W. Montgomery Ave., Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |



11:11
11:11
11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102672

| | | | | | |
|--|--|---|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| Pauline B Vetter | | 1 5 81 | | 4 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR
MONTHS DAYS | |
| F | C | 08-15-95 | 85 YRS. | | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| VIRGINIA USA. | USA. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville Md. | Shady Grove Adventist Hosp | Housewife | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MARYLAND | MONT. | Gaithersburg | YES <input type="checkbox"/> NO <input type="checkbox"/> | 103 N. Summit Ave., | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| William Day | Ellen Racey | 217-162753 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | |
| NO | | Elmer E. Vetter | PART 1. DEATH WAS CAUSED BY: | | |
| | | | IMMEDIATE CAUSE (a) Cardiorespiratory arrest | | |
| | | | 1539 DUE TO, OR AS A CONSEQUENCE OF | | |
| | | | (b) Electrolyte imbalance | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | |
| | | | (c) Adenocarcinoma of the colon | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Hypalbuminemia | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 4, 19 81, to Jan 5, 19 81, that (I) (we) lost saw the deceased alive on Jan 4, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| James R. Moore Jr. | | MD | | 1-5-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| James R. Moore Jr. | | 207 Brookes Ave Gaithersburg Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | Jan. 7, '81 | Forest Oak Cemetery | Gaithersburg Montg. Maryland | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Gartner Sandison F. H. | 316 E. Diamond Ave. Gaithersburg, Md. | | JAN 9 1981 | | |

Montgomery

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

1987-1988

1989-1990

1991-1992

1993-1994

1995-1996

1997-1998

1999-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102673

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|--|--------------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM HUBERT VOSE | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 22, 1981 | | 2b. HOUR
3²⁵ AM | | | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 9, 1925 | | 6 AGE (IN YEARS LAST BIRTHDAY)
55 | | 7. UNL. 1 YEAR
MONTHS DAYS HOURS MIN
YRS | | 8. UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(INDICATE WORK FORMER PART OF WORKING LIFE)
STATIONARY ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
WASHINGTON HOTEL | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
PRINCE GEO. | | 13c. CITY OR TOWN
BRENTWOOD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3908 PERRY STREET | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM K. VOSE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AMRY WRIGHT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
WW II | | 17 INFORMANT
5300 Avenue
David H. Tulloss Riverdale, Maryland 20840 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Large Cell Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) 7 months
1639
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
13 Sept 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
13 Sept 80 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
22 Jan 81 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 13 Sept 80 to 22 Jan 81 , that (I) (we) lost the deceased alive on 21 Jan 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas A. Benesneber, MD
DEGREE
MD | | | | | | | | 22c. DATE SIGNED
1/22/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas A. Benesneber, MD | | | | | | | | 22e. ADDRESS
7626 New Hampshire Ave Langley Park MD 20723 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | | | | 23b. DATE
1/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Pratt's Sons Funeral Home, P.A.
ADDRESS
Hyattsville, Maryland | | | | | | | | 25. DATE RECEIVED BY REGISTRAR
JAN 26 1981 | | | |

1303

Residential Technology
Medical Case Management Service

13/05/01

13/5/01

James H. Bourke, MD, PhD
James H. Bourke, MD, PhD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 7 4

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GLADYS LOUISA WAGNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JAN. 28, 1981 | | | 2b. HOUR
0136 M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 15 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 13a. USUAL RESIDENCE (IF MAKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN BALTIMORE | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE DUNCAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian PRATT | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-01-2494 | | 17. INFORMANT
ADDRESS
REV. RICHARD REICHARD 9701 VEIRS DR. ROCKVILLE, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4413 IMMEDIATE CAUSE (a) ruptured abdominal aortic aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 11, 1979, to Jan. 28, 1981, that (I) (we) lost
saw the deceased alive on Jan. 27, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold F. McCann | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-28-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | | | 22e. ADDRESS
3955-16th St. N.W. WASH. D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
FEB. 2, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
MORELAND MEMORIAL PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
THE Hysong Company | | | | ADDRESS
1300 N St. NW Wash DC | | 25. DATE REC'D BY REGISTRAR
FEB 5 1981 | | 25b. REGISTRAR'S SIGNATURE | |

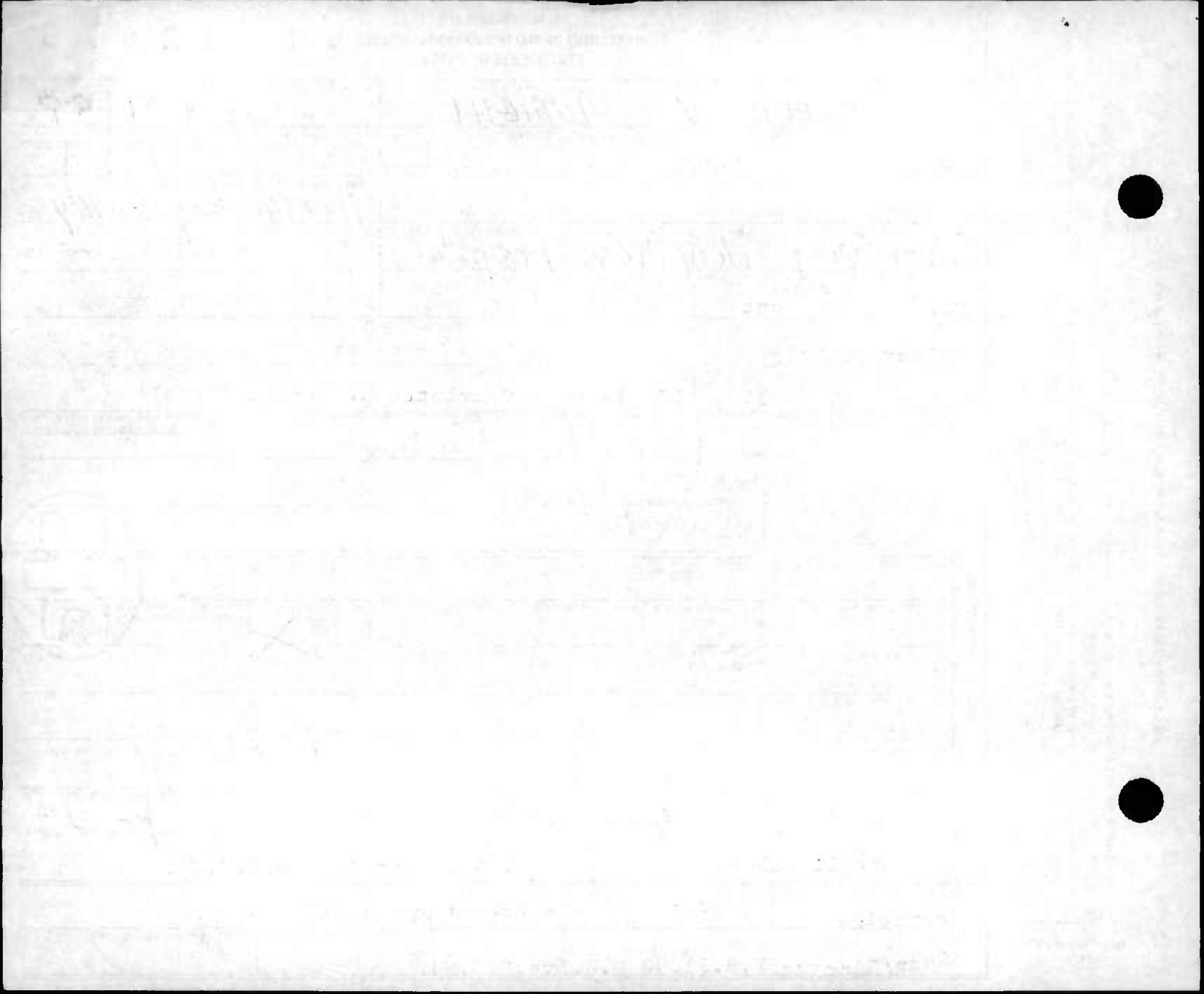


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EDWARD V WAIGHT | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-29-81 | | | | | 2b. HOUR
8:44 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 25, 1920 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self-Employed | | | 12b. KIND OF BUSINESS OR INDUSTRY
Laundry Mat | |
| 13a. STATE
Md. | | | | | 13b. COUNTY
PG | | 13c. CITY OR TOWN
Adelphi | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Volney J. Waight | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Etta Herr-Neckar | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
WWII | | 17. INFORMANT
ADDRESS Same as above
Charlotte L. Waight (Wife) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1, 1980 , to 1-29-81 , that (I) (we) last saw the deceased alive on 1-29-81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Carroll D. Mahoney M.D. | | | 22c. ADDRESS
10301 Georgia Ave. S.S.Md. | | | 22d. DATE SIGNED
1-30-81 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wash. D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 2 1981 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2700 BP

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

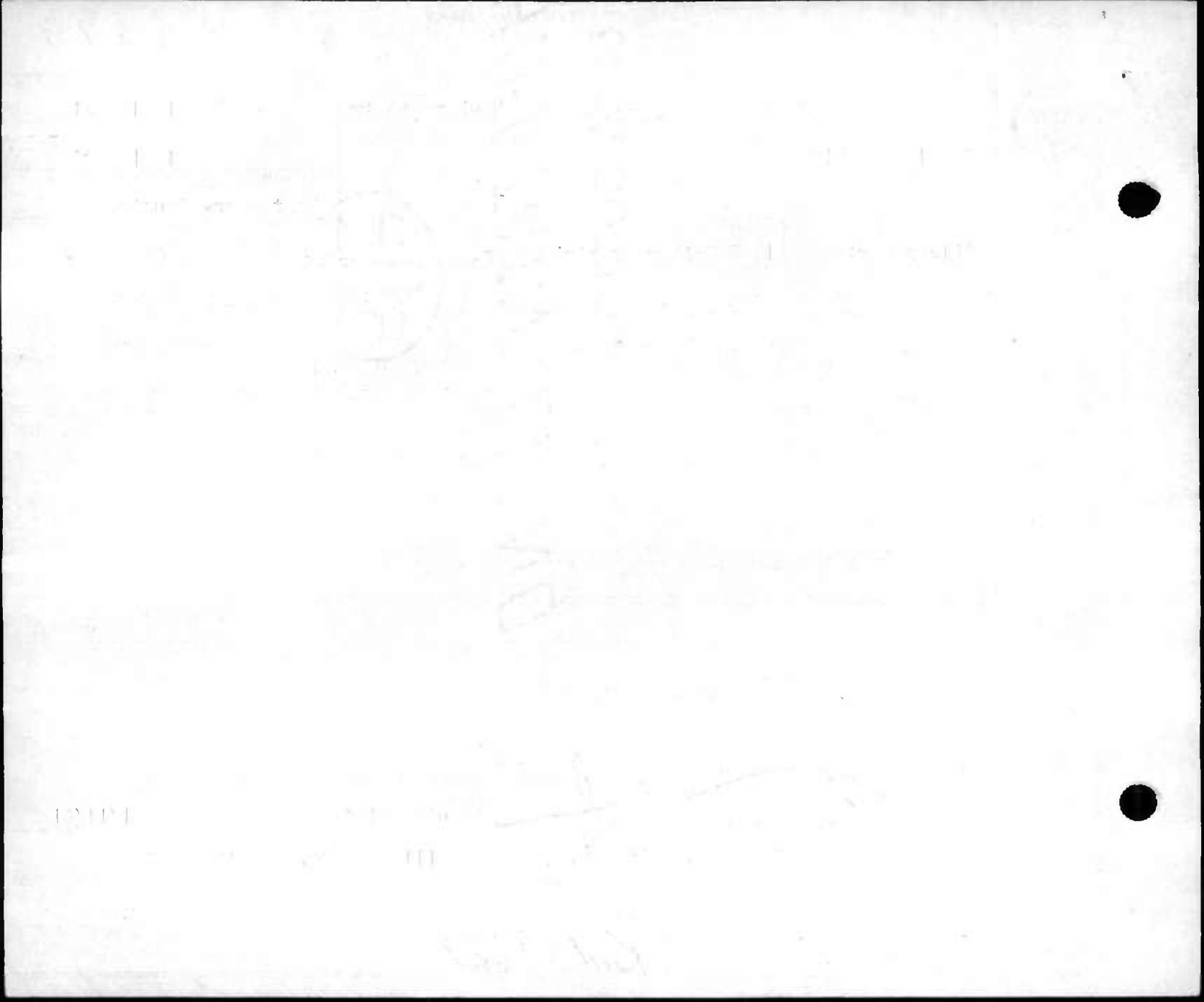
8102676

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MOLLIE | | | 2a. DATE OF DEATH MONTH DAY YEAR
JANUARY 1, 1981 | | | 2b. HOUR
5:30 P.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 17 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
5 30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR IND.
PAT. ATTY. OFFIC | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
CHEVY CHASE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8513 FARRELL DRIVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ABRAHAM KOLKER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
IDA DRYER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-34-0217 | | 17. INFORMANT ADDRESS
HARRY WALDSTREICHER, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial
4100 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Acute | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Deceased mellitus
Dermat. mycosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1800 EYE STREET, N. W., WASHINGTON, DC | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13 19 84 to 1/1 19 81 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Herbert Wechsler | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herbert Wechsler | | | | 22e. ADDRESS
1800 EYE STREET, N. W., WASHINGTON, DC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/4/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT LEBANON CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI. PRINCE GEORGES, MD. | | 23e. DATE REC'D. BY REGISTRAR
JAN 9 1981 | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | |

MEDICAL CERTIFICATION

BP_____

DHMH-17
(VR A15 ME (5))
15M2/80



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 5 7 8

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN W WALKER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 14 81 | | 2b. HOUR 1:00 P.M. |
| 3 SEX F | 4 RACE W | 5 DATE OF BIRTH MONTH DAY YEAR 12 12 01 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10 CITY OR TOWN OF DEATH GAITHERSBURG | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 31 NANCY PLACE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY BANKERS ASSN OF WASH. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | | 13b. COUNTY MAY | 13c. CITY OR TOWN GAITH | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT C. WILSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE BOYD | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 577 346 424 | | 17 INFORMANT DAUGHTER BARBARA DENNISON ADDRESS 6505 FARMINGDALE CT. DERWOOD, MARYLAND | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Hypertension | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from april 19 77 to January 19 1981 , that (I) (we) last saw the deceased alive on Oct 23 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Cheryl Winchell | | DEGREE | | 22c. DATE SIGNED 1/15/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHERYL WINCHELL | | 22e. ADDRESS 19241 MONTGOMERY VILLAGE AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY | |
| 23d. LOCATION WASHINGTON, D.C. | | STATE | | | |
| 24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | 24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

00

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 2 6 7 9

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Thomas Murray Warburton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-20-80 | | 2b. HOUR
8:29 P.M. | | | | |
| 3. SEX
Male. | | 4. RACE
White. | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 10, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Toronto, Canada. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
General Maintenance. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland. | | | | | | | | | |
| 13b. COUNTY
Montg. | | | | | | | | | |
| 13c. CITY OR TOWN
Silver Spring. | | | | | | | | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 13e. STREET ADDRESS
8406 N. H. Ave. S. S. Md. | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas F. Warburton. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Suzanne Tobin. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes. | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-42-2865 | | | | |
| 17. INFORMANT
ADDRESS
Marion Warburton (Wife) | | | | | 13 e | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest from Ventricular Fib.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 hr. 45 min.

3989
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Rheumatic Heart Disease

37 years

DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac myopathy

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 Jan 1965 to 20 Jan 1980, that (I) (we) last
saw the deceased alive on 19 Jan 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Russell B. Arnold M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
1/20/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Russell B. Arnold M.D. | | | | 22e. ADDRESS
1106 Spring Street,
Silver Spring, Md. 20910 | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial. | | 23b. DATE
Jan. 26, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Hills. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Scarborough Co. Toronto Canada | |
| 24. FUNERAL DIRECTOR
(NAME)
Takoma Funeral Home.
254 Carroll St. N. W. D. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE
Tracy McCreedy | |



Thomas Murray Watburton

May 1, 1933

Mont.

Washington Adventist Hospital General Maintenance.

Arland, Mont. Oliver, Mont. +

Thomas F. Watburton.

214-67-7073 (Wife) 1933

Watburton, Co. Toronto

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

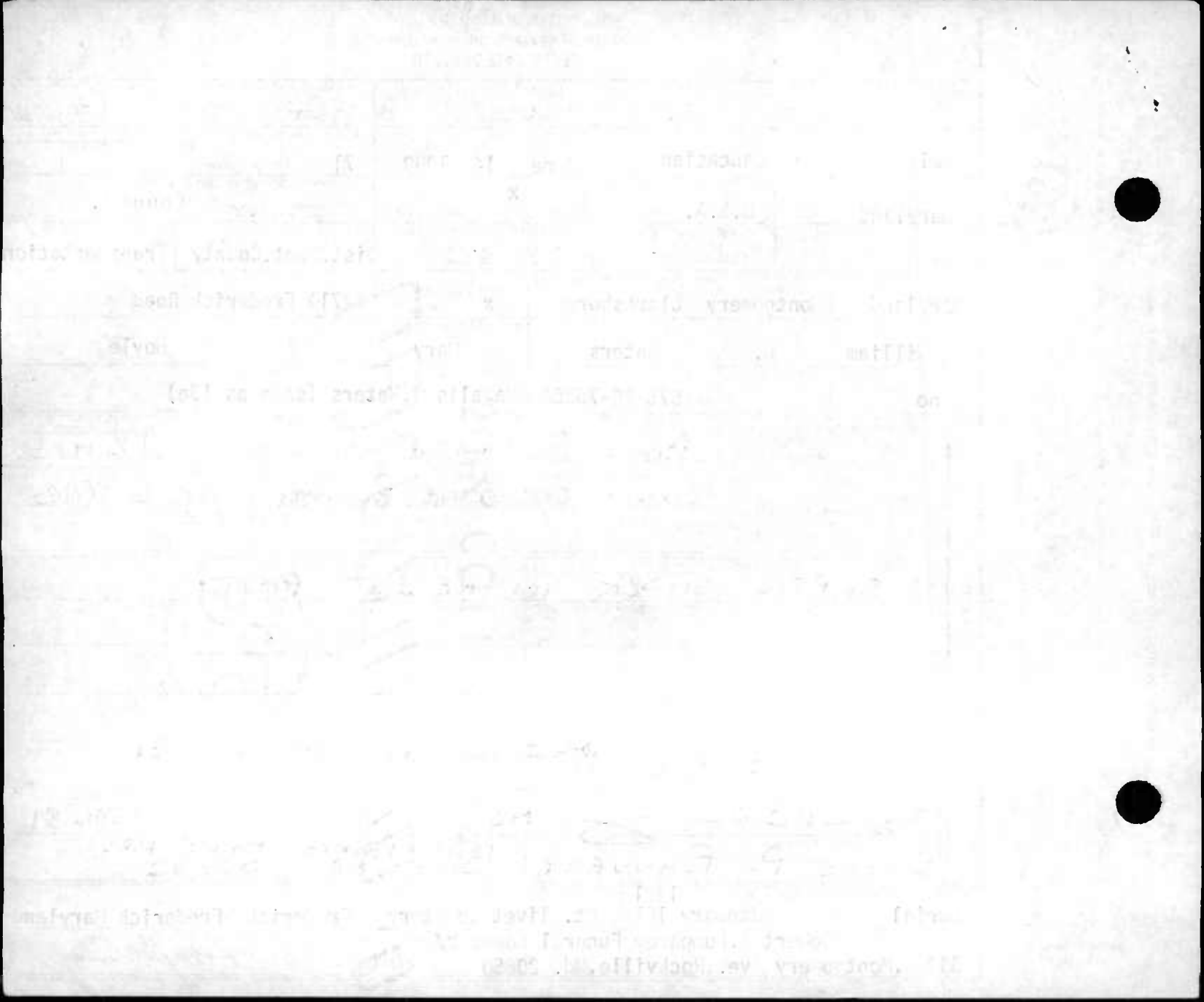
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 8 0

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert L. Waters | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 13, 1981 | | 2b. HOUR
10:00AM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
June 14 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dist. Supt. County | | 12b. KIND OF BUSINESS OR INDUSTRY
Transportation |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | |
| 13c. CITY OR TOWN
Clarksburg | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS
24710 Frederick Road | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Waters | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Hoyte | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
578-26-7526A | | 17. INFORMANT
ADDRESS
Magalis D. Waters (same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE
4960
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE, SEVERE
DUE TO, OR AS A CONSEQUENCE OF
(c) 1 1/2 HRS.
6 YEARS. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
SEPTIC SHOCK IN RECENT PAST. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981 to JAN 13 19 81 , that (I) (we) lost saw the deceased alive on JAN 13 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Eugene P. Flannery | | DEGREE
MD | | 22c. DATE SIGNED
13 JAN 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. FLANNERY | | 22e. ADDRESS
18111 PRINCE PHILIP PR. OLNEY, MD. 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick Frederick Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | ADDRESS
Funeral Homes P/A | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | |
| 25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 1 0 2 6 8 1 | | | |
|--|--|---|--|---|---|---|--|--|--------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Maynard D Watkins | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 13 81 | | | | 2b. HOUR
9:00P | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 30, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7. IF UNDER 24 HRS.
HOURS MIN.
0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
23101 Davis Mill Rd. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willard - Watkins | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotte - Williams | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-36-7257 | | 17. INFORMANT
ADDRESS
Charlotte Kauffman, 2105 Woodberry St. Hyattsville, Md. 20782 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a):
4860 Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last:
Chronic Heart Failure
DUE TO, OR AS A CONSEQUENCE OF:
Diabetic Gravidity
PART 2. OTHER SIGNIFICANT CONDITIONS CONTINUING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Absolute Cholesterol - Old CVA | | | | | | | | | | ATTENDING PHYSICIAN'S SIGNATURE
5 days
10 days | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1 13 81
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF POLICY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
1110 | | 21f. LOCATION
STREET
1814 P St | | CITY OR TOWN
Phila | | COUNTY
Del | | STATE
MD | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/13/81 to 1/13/81 that (1) (we) last saw the deceased alive on 1/13/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) see the body after death. | | | | | | | | | | 22c. DATE SIGNED
1/14/81 | | | |
| 22b. SIGNATURE
C. H. Ligon | | | | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
C. H. Ligon | | | | 22d. ADDRESS
1814 P St, Phila, Md 21552 | | 22e. DATE SIGNED
1/14/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 17, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Upper Seneca | | 23d. LOCATION
CITY OR TOWN
Cedar Grove, Montg., Md. | | COUNTY
Montg. | | STATE
Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., Damascus, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 8 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Regina Catherine Watkins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-5-81 | | 2b. HOUR
MIN.
12 15 PM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
8 26 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assignment Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
C & P |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
9113 WIRE AVENUE 20901 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERBERT WATKINS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA C. CALLAHAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
223-03-6756 | | 17. INFORMANT
ADDRESS
COUSIN ANN E. KEEGAN 4201 MASS. AVENUE, WASHINGTON, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordian respiratory arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis - Coronary Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months
months
years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Emotion. Arteriosclerosis. Cerebral Arteriosclerosis. Arterial Hypertension. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 70 to January 5 1981 , that (I) (we) lost
saw the deceased alive on January 5 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Hugo B. Graziani | | DEGREE
M.D. | | 22c. DATE SIGNED
1-5-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUGO B. GRAZIANI | | 22e. ADDRESS
806 Parkway N. 303 A S-S Md 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROOD CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. SIGNATURE
Francis J. Collins | |
| 26. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

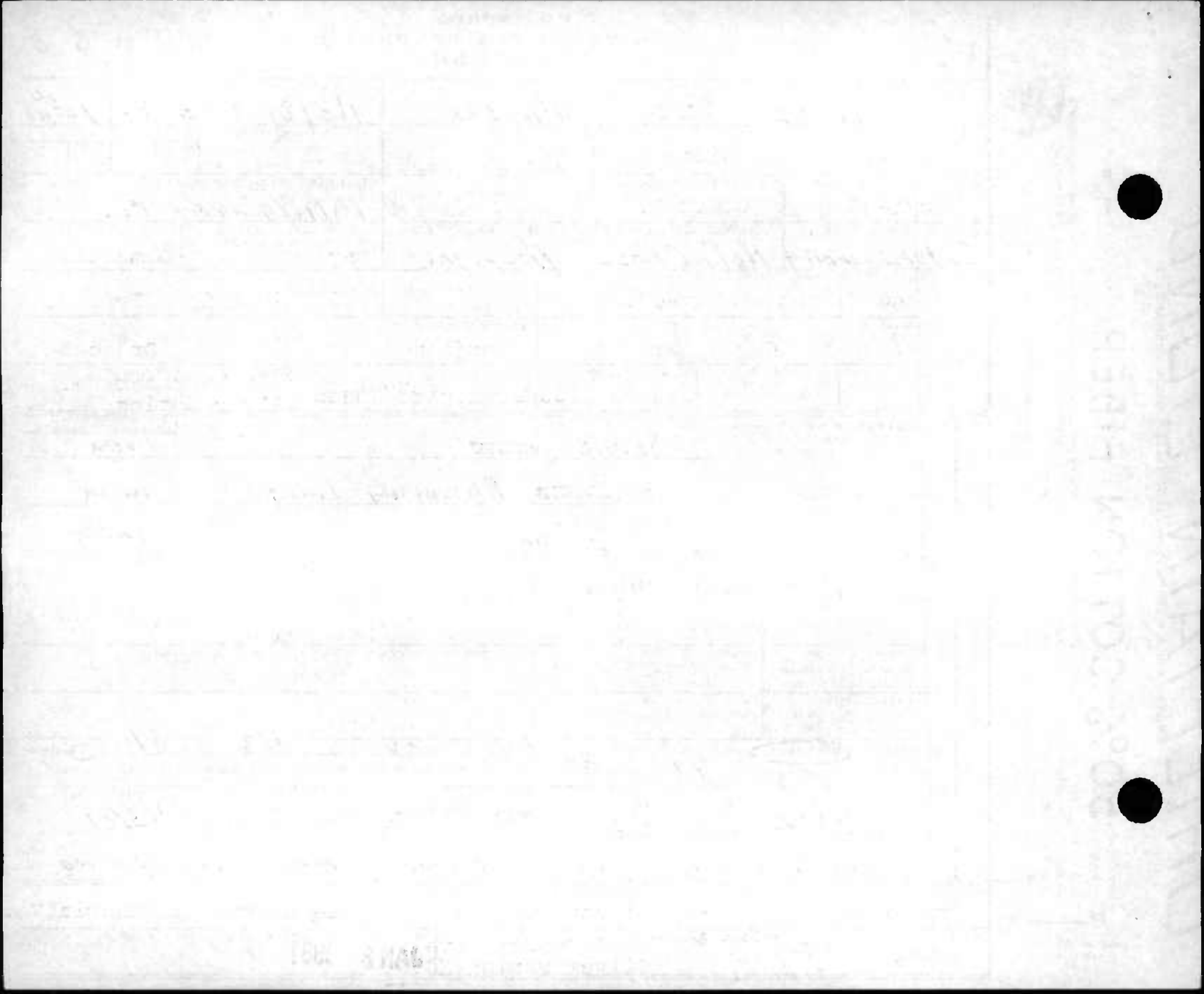
ORIGINAL
NOTED
2000-01-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 2 6 8 3 | |
|---|--|--|--|---|--|---|--|--|---|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) LOUISE B. WATSON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11/3/81 1 3 81 | | | 2b. HOUR
12:50 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11- 13- 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. & A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1131 University Blvd. W. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel C. Bready | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Georgianna Bruscup | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
266-92-2633 | | 17. INFORMANT (daughter) ADDRESS
Marguerite Jones 2000 Marymont Rd. Silver Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS, BACTERIAL
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
4860
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
RHEUMATOID ARTHRITIS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
1 WEEK
1 WEEK | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 12/27 19 80 , to 1/3 19 81 , that (I (we) last saw the deceased alive on 1/1 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert L. Rosenberg | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/3/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. ROSENBERG, MD | | | 22e. ADDRESS
1131 UNIVERSITY BLVD, W, SILVER SPRING MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
1-6-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Alexandria, Va. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Warner E. Pumphrey, Inc | | | ADDRESS
8434 Georgia ave Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Patricia Lee Wayne | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
01 19 81 | | 2b. HOUR
12:07^{PM} | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
02 27 40 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS
40 | | 7 UNDER 1 YEAR MONTHS DAYS
0 0 | | 7 UNDER 24 HRS HOURS MIN
0 0 | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 9 CITIZEN OF WHAT COUNTRY?
USA | | 10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 12 CITY OR TOWN OF DEATH
Takoma Park | | 13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 14 USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cosmetician | | 15 KIND OF BUSINESS OR INDUSTRY
Beauty shop | | | |
| 16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Prince Geo. | | 13c. CITY OR TOWN
Lanham | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7007 Woodside Dr. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Gerald A. Weikel | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Ruby Byrne | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no none | | 16b. SOCIAL SECURITY NO
403-50-2234 | | 17 INFORMANT (husband) ADDRESS
Robert L. Wayne - (same as 13e) | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral Edema
DUE TO, OR AS A CONSEQUENCE OF (b) Brain Metastasis
DUE TO, OR AS A CONSEQUENCE OF (c) Breast CA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk
1 wk
4 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Liver, Bone, Bone marrow metastasis | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/16/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
- | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
- | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
- | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Oct 19 80 to 1/19 81 , that (1) (we) last saw the deceased alive on 1/16/81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Peter Sherer | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/19/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER B. SHERER, MD | | 22e. ADDRESS
1109 Spring St. #610 Silver Spring Md 20910 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-22-1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Mater Deice Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Owensboro Davis Ky. | | | | | |
| 24. FUNERAL DIRECTOR
Wagner E. Pumphrey, Inc.
8434 Ga. Ave., S.S. Md. | | | | | | | | | | | |

07:12:12

Principles of Law

Montgomery County

Washington Adventist Hospital

7007 Woodside Dr.

Central Cinema
Frankford
CA

Frankford

1-11-11

1-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 8 5

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY ELIZABETH WEINLEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 4, 1981 | | 2b. HOUR
10:45 A |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 11, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH CLINICAL CENTER, BETHESDA, MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own home |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
ROCKVILLE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew Miklesh | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Reaser | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
386-48-0725 | | 17. INFORMANT
ADDRESS (SAME AS ABOVE)
MISS LISA M. WEINLEIN, DAUGHTER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
1749
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) METASTATIC BREAST CANCER
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 MIN
6 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from JANUARY 2, 19 81 , to JANUARY 4, 19 81 , that (X) (we) lost the deceased alive on JANUARY 4, 19 81 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE
(Srinivasan-G) | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
1/4/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
(Srinivasan-G) | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD. 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Monocacy | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Beallsville-Mont. Md | | 24. FUNERAL DIRECTOR
NAME
W. W. Chambers Co. Silver Spring, Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE
(Signature) | | | |

1801: I HAL

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2500 BP

| 1 - STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 1 0 2 6 8 6
REG. NO. | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Samuel Weinzier</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1 26 81</i> | | | | 2b. HOUR
<i>0645AM</i> | | | |
| 3. SEX
<i>M</i> ALE | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>9 25 08</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>72</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>NEW JERSEY</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>SALESMAN</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>RETAIL</i> | | | |
| 13a. STATE
<i>MD</i> | | | | 13b. COUNTY
<i>Mont.</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS APT. #
<i>8705 Georgia Avenue #20910</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>ZIGMUND WEINZIER</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>ANNIE UNKNOWN</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | | | 16b. SOCIAL SECURITY NO.
<i>124-03-7729</i> | | 17. INFORMANT <i>MRS. BESSIE WEINZIER</i>
<i>8750 GEORGIA AVE., APT. 321A SILVER SPRING, MD. 20910</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>4100</i>
IMMEDIATE CAUSE (a) <i>Cardiac repolarization arrest</i>
DUE TO, OR AS A CONSEQUENCE OF <i>renal failure</i>
(b) <i>Myocardial infarction, shock lung</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial infarction cardiac</i>
(c) <i>Myocardial infarction cardiac</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hour</i>
<i>15 days</i>
<i>19 days</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <i>1-25-81</i> to <i>1-26-81</i> , that (II) (we) last saw the deceased alive on <i>1-25-81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John A. Galotto MD</i> | | | | 22c. DATE SIGNED
<i>1/26/81</i> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>John A. Galotto MD</i> | | | | 22e. ADDRESS
<i>5225 Packer Hill Rd
Baltimore, MD 21204</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>BURIAL</i> | | 23b. DATE
<i>1/27/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>HAR ZION TIFERETH ISRAEL</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>ROSEDALE BALTO. MD</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME <i>SOL LEVINSON & BROS., INC.</i>
ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 28 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Esther K. K... ..</i> | | | | | |

0012

1900

Received of the
Hon. Secy. of the Navy
the sum of \$100.00
for the purchase of
the sum of \$100.00

for the purchase of
the sum of \$100.00
for the purchase of
the sum of \$100.00

for the purchase of
the sum of \$100.00
for the purchase of
the sum of \$100.00

1900

1875

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02687

FOR
1- STATE
REGISTRAR

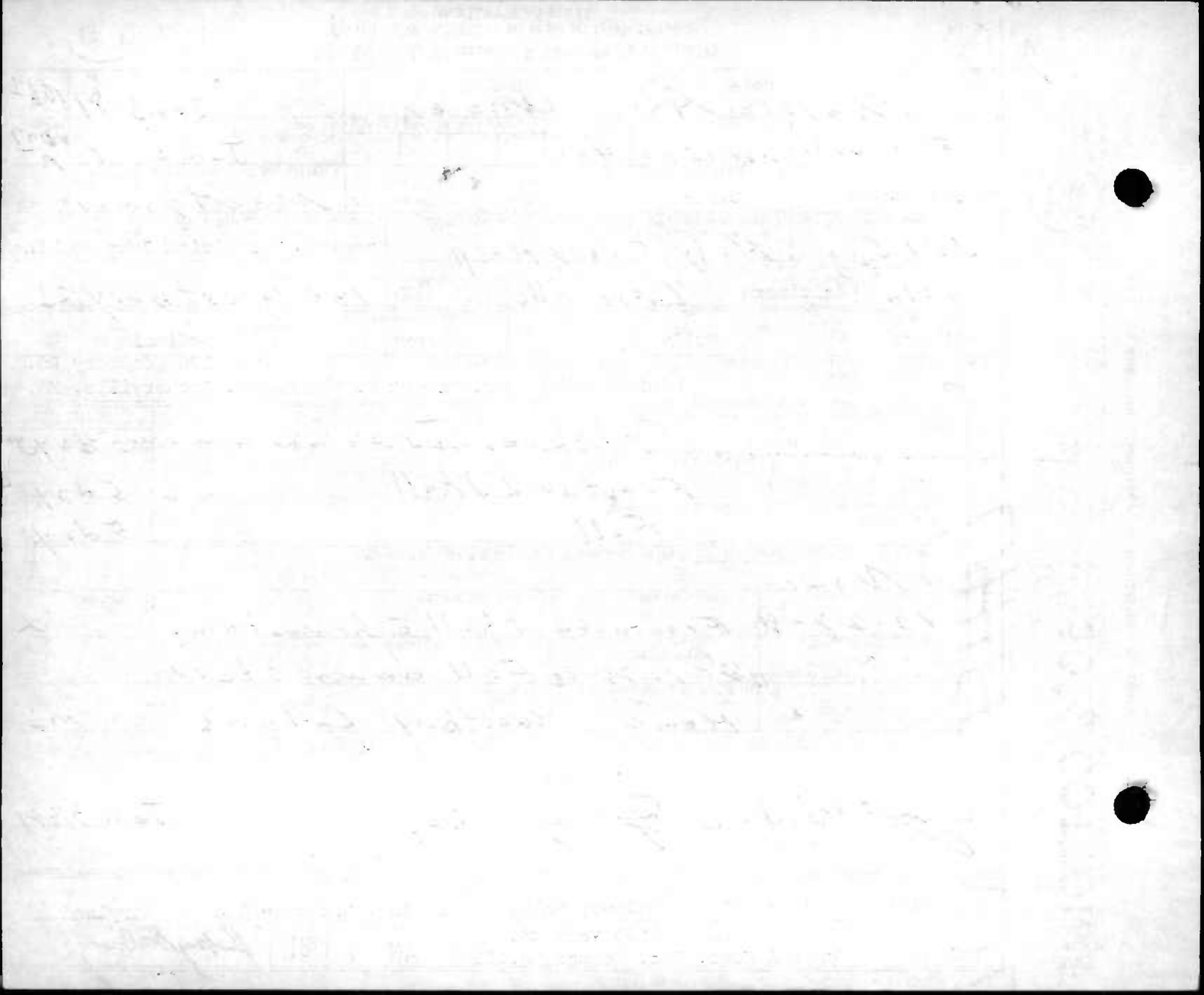
| | | | | | |
|---|----------------------|---|---|---|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Marcia Ann Whelen | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jan 3 1981 | | 2b. HOUR OF DEATH 10:42 AM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH
MONTH DAY YEAR Mar. 15 37 | 6. AGE (IN YEARS)
LAST BIRTHDAY 43 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7. IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
St. Louis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Louis Spaulding Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Research Technician | |
| 13a. STATE Md | | 13b. CITY OR TOWN Lutherville | | 13c. STREET ADDRESS
136 Westbury Rd | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Tully | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura McGinnis | | 12b. KIND OF BUSINESS OR INDUSTRY
John Hopkins | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
002-26-6078 | | 17. INFORMANT
Mr. Robert P. Whelen, Sr. | |
| | | | | ADDRESS 136 Westbury Rd. Lutherville, Md. | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Trauma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Fractured Skull
DUE TO, OR AS A CONSEQUENCE OF
(c) Fall | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
5 days
5 days |
|--|--|---|

| | | |
|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | |
| 19a. DATE OF OPERATION
12-28-80 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fractured skull & hematoma | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
6:30 P.M. 12 28 80 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Fell down stairs |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Westbury Lutherville Md |

| | | |
|--|--|--|
| 22a. I certify that I took charge of the remains described above, held on death resulted from:
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |
| ACTUAL SIGNATURE Robert P. Whelen | | TITLE (SPECIFY)
M.D. Dap MEDICAL EXAMINER |
| EXAMINER'S NAME
(TYPE OR PRINT) | | DATE SIGNED Jan 3/1981 |

| | | | |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1-6-81 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. Gdns. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1981 | 25b. REGISTRAR'S SIGNATURE
Robert P. Whelen |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Kildred A Whitlow</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>1-12-81</i> | | 2b. HOUR
<i>11:55A</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>CAUCASIAN</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>5-5-96</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>84</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Washington, D.C.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>WASHINGTON Adventist Hosp</i> | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
<i>Md.</i> | 13b. COUNTY
<i>Mont.</i> | 13c. CITY OR TOWN
<i>Silver Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>12411 Good Hill Rd.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Wilbur Joseph Mc DANIEL</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary Hunt</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>404-32-8132</i> | 17. INFORMANT son
<i>Charles S. Whitlow</i> ADDRESS
<i>7009 18th Ave. Hyattsville, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac asystole</i>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>cardiogenic shock</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>acute myocardial infarction</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from <i>1-11</i> , 19 <i>81</i> , to <i>1-12</i> , 19 <i>81</i> , that (b) (we) last saw the deceased alive on <i>1-12</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>John Kijack</i> | | DEGREE
<i>MD</i>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-12-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>John Kijack M.D.</i> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>Jan. 14, 1981</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Suitland Pr. Geo. Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Francis J. Collins</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 16 1981</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Francis J. Collins</i> | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | |

2051



Main body of handwritten text, appearing as a list or series of entries across the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|---|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. 81 02689 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
RUDOLPH G WHITTEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
01 08 81 | | | 2b. HOUR
205 P M | | |
| 3. SEX
MALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR
03 10 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS | | IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL NAVA MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ARMED FORCES | | 12b. KIND OF BUSINESS OR INDUSTRY
GOVT. | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN L WHITTEN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
1909-1945 | | 17. INFORMANT
RUDOLPH G WHITTEN JR | | ADDRESS
12122 WHIPPOORWILL LANE ROCKVILLE, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>
4360
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC. 17, 19 80, to JAN. 8, 19 81, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Joseph F. Hacker M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
JAN. 9, 1981 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.F. HACKER M.D. | | | | | 22e. ADDRESS
BETHESDA, MD.
NATIONAL NAVAL MEDICAL CENTER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
1-10-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR
LEE FUNERAL HOME | | | | | WASHINGTON DC 20002 | | 25a. DATE REC'D BY REGISTRAR
JAN 16 1981 | | | |

U.S. and Allied

Government of the

1-1-11

1-1-11

VAL

200

5

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102690

REG. NO.

| | | | | | |
|--|---|--|---|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| PAUL FRANCIS WIDMAYER | | | | JAN 19 81 1:15 PM | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| MALE | WHITE | MONTH DAY YEAR
APRIL 6, 1908 | 72 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| WASHINGTON, D. C. | U.S.A. | | MONTGOMERY MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | BETHESDA HEALTH CENTER | ENGINEER | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | |
| MARYLAND | MONTGOMERY | ROCKVILLE | | 12630 VIERS MILL ROAD | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | 16. SOCIAL SECURITY NO. | | | |
| JOHN J. WIDMAYER | ELLEN C. HICKEY | 578-36-2170 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | 17 INFORMANT | ADDRESS | | |
| NO | 578-36-2170 | ANN E. WIDMAYER | SAME AS 13 WIFE | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4409 } DUE TO, OR AS A CONSEQUENCE OF
(b) }
(c) }
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19-81 to 1-19-81, that (I) (we) lost saw the deceased alive on 1-19-81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
ROBERT KRAMER | | 22c. DATE SIGNED
1/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| ROBERT KRAMER | | 830 FERTIN RD. SILVER SPRING | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| BURIAL | 1/22/81 | GATE OF HEAVEN | SILVER SPRING MONT MD. | | |
| 24 FUNERAL DIRECTOR FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| | | | JAN 22 1981 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0.050 13

0.050 13

0.050 13

0.050 13

0.050 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner notified and released 1/3/87
 1 - STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. *10315*

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Charles Frederick Wilhelm</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>January, 3 81</i> | | 2b. HOUR
<i>3:41 AM</i> |
| 3. SEX
<i>Male</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>March 15, 1913</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>67</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County, MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Shady Grove Adventist Hosp.</i> | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Manager</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Auto Dealer</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
<i>New York</i> | 13b. COUNTY
<i>Dutchess</i> | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
<i>13 Gleason Blvd.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Frederick Wilhelm</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Margaret McCarthy</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>073-01-2455</i> | | 17. INFORMANT
<i>Frederick Wilhelm Gleason Blvd. Pleasant Valley, NY.</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>EXT CARDIOGENIC SHOCK</i>
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) <i>EXTENSIVE MYOCARDIAL INFARCTION</i>
24 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>HYPERTENSION</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs</i> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>12 19 81</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/2</i> 19 <i>81</i> to <i>1/3</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>1/2</i> 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
<i>Roger Stevenson Jr</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1/3/81</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ROGER STEVENSON, JR</i> | | 22e. ADDRESS
<i>11125 ROCKVILLE PIKE, ROCKVILLE, MD</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | 23b. DATE
<i>January 6, 1981</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Peter's Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Poughkeepsie New York</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Robert A. Pumphrey Funeral Homes, .PA., Bethesda, Maryland</i> | | 25a. DATE REG'D BY REGISTRAR
<i>JAN 7 1981</i> | | |

10-10-68

Jarvis F. H.
667-3815

4

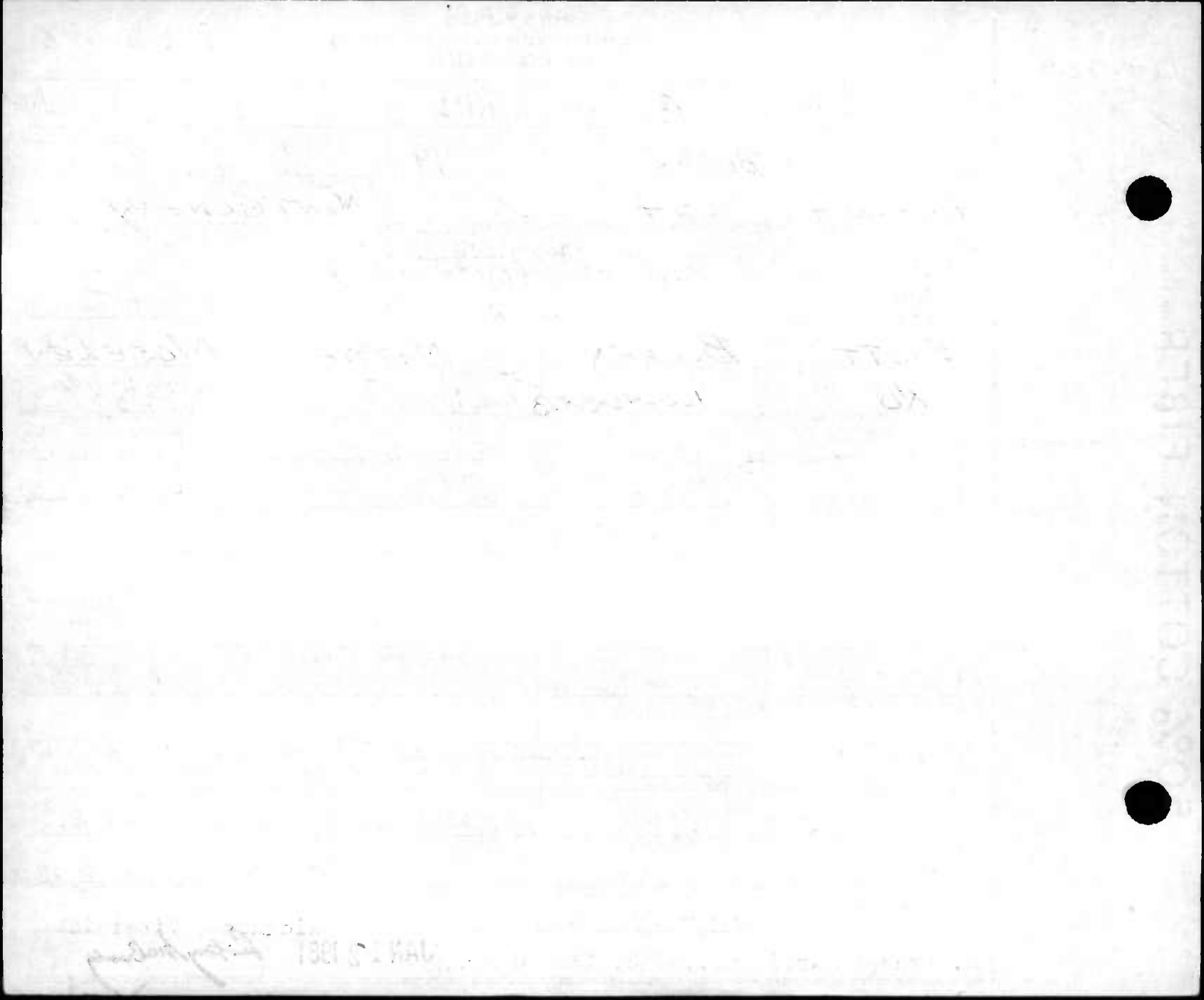
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 81 02692 | |
|---|--|--|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) LYDIA C. WILLIAMS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 08-81 0830AM | |
| 3. SEX F | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 11 30 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) COLLINGSWOOD NURSING CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADJUNCT HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE NY | 13b. COUNTY NY | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS CORNISH ARMS APT. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SCOTT BOOKER | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE MOSELEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | |
| 16b. SOCIAL SECURITY NO. 100-42-0823 | | 17. INFORMANT NAME AND ADDRESS JOHN RISHEN JR. 3311-CLEVELAND AVENUE W. WASH D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
4370
DUE TO, OR AS A CONSEQUENCE OF
(b) Viral pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral & generalized arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 min
11 days
5 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypoxemia Anemia decubitus ulceration Peptic disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 18 19 80 to Jan 8 19 81 , that (I) (we) last saw the deceased alive on Jan 8 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE James B. Modreski DEGREE MD | | | | 22c. DATE SIGNED 1-8-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James B. Modreski | | | | 22e. ADDRESS 207 Brooker Ave Gaithersburg Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/12/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Local | |
| 23d. LOCATION CITY OR TOWN Richmond COUNTY Virginia STATE VA | | 25. DATE REC'D BY REGISTRAR Jan 12 1981 | | | |
| 24. FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc. ADDRESS 1432 U St. | | | | | |

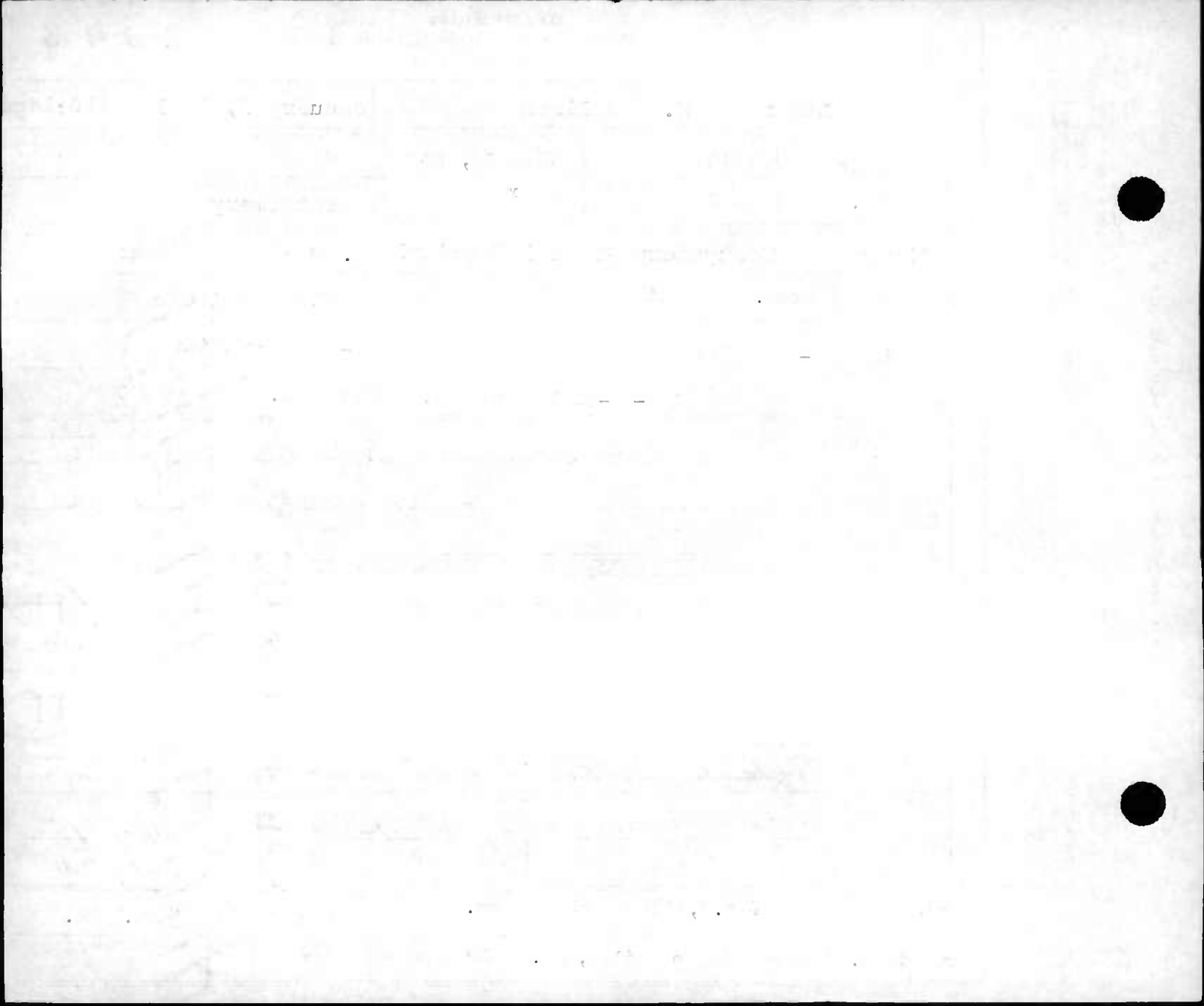


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Linda W. Willson | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 6, 1981 | | 2b. HOUR
MIN.
10:14pm | |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
June 30, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H. Wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin - Waters | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary - Griffith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
217-36-6269 | | 17. INFORMANT
ADDRESS
Frank F. Willson, Sr. Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 yrs | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 6, 1981 to Jan 6, 1981 , that (I) (we) last saw the deceased alive on Jan 6, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. D. BOHART MD | | | | 22c. DATE SIGNED
1/6/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. D. BOHART | | | | 22e. ADDRESS
18111 Prince Philip Dr. Olney Md | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
Jan. 9, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Friends Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring Mont. Md. | | 23e. REC'D. BY REGISTRAR
JAN 9 1981 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis H. Barber Laytonsville, Md. 20760 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8102694 | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ELEANOR BESSETT WILSON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 24 81 | | 2b. HOUR
9 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JAN 25, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
68 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CONNECTICUT | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SLIGO GARDENS NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9039 SLIGO CREEK PARKWAY | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ELMER BESSETT | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
SARAH LEVERITY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-26-0353 | | 17. INFORMANT
EDMUND P. WILSON | | ADDRESS
SAME AS 13 HUSBAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROASCULAR THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
AUG 1980 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from SEPT 1980 to 24 JAN 81 , that (we) last saw the deceased alive on 31 DEC 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Walter E. Goetz</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
24 JAN 81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOZH MD | | | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
1/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE
<i>Ray A. [unclear]</i> | | | |
| ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |

MEDICAL CERTIFICATION

BP

WILSON 21 MAY 1960

(M)

WILSON 21 MAY 1960

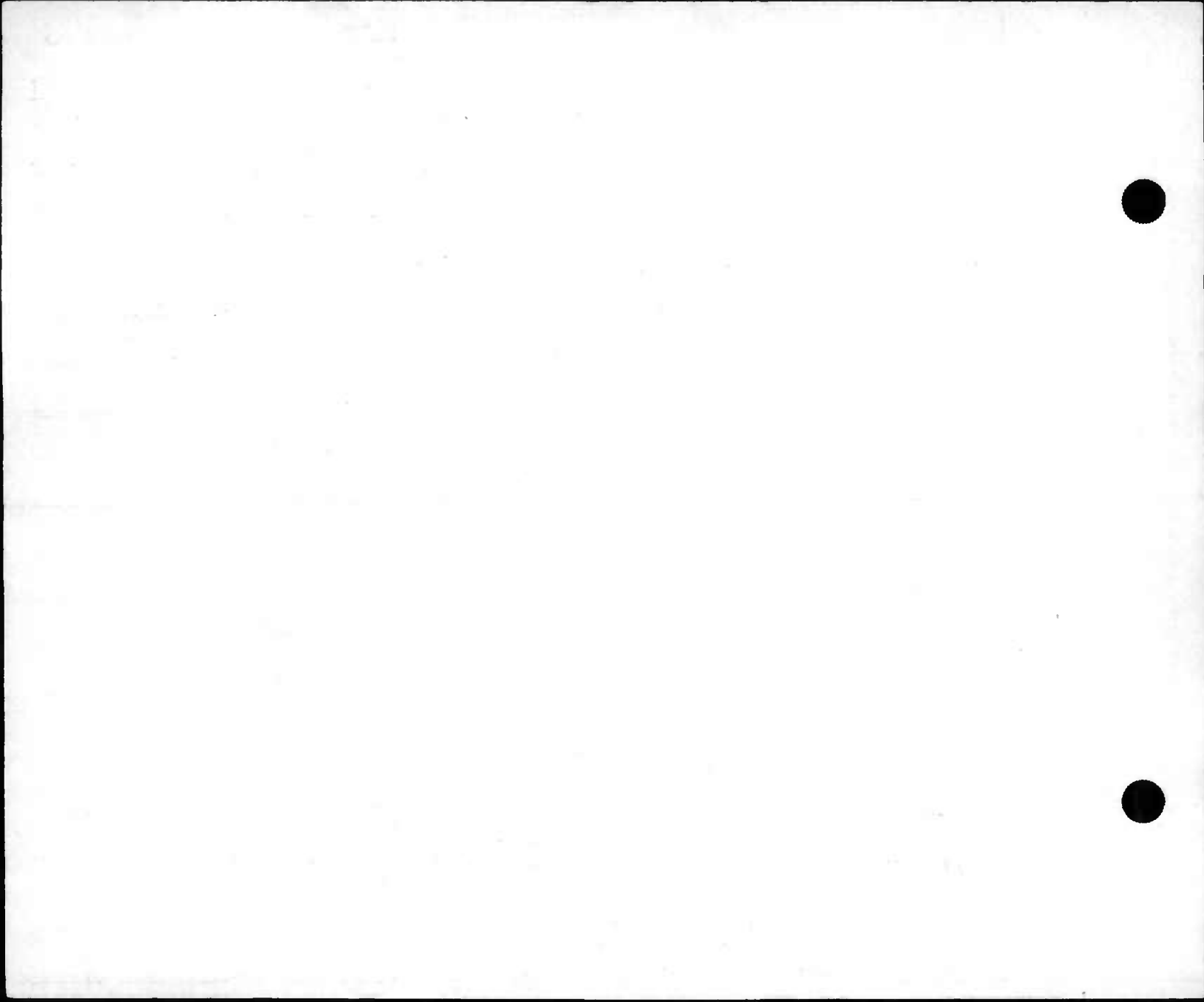


WILSON 21 MAY 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8102695 | | | |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) BETTY Jane WINDRIDER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1/05/81 | | 2b. HOUR
MIN.
6:30 A | |
| 3 SEX
FEMALE | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
7 25 35 | | 6 AGE IN YEARS (LAST BIRTHDAY)
45 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | | | 13b. COUNTY
Anne Arunde | | 13c. CITY OR TOWN
Pasadena | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Cumor | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Slechter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-34-0754 | | 17 INFORMANT
ADDRESS
Windrider
Mr. Avery L. Windridge same | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Metastatic cancer of Lungs from
1749
DUE TO, OR AS A CONSEQUENCE OF Breast carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
- | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
- Baltimore Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 80 , to 1-5 , 19 81 , that (I) (we) lost saw the deceased alive on 1-4 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. Shamim MD | | | | DEGREE
MEDICAL
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1-5-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AHMAD SHAMIM | | | | 22e. ADDRESS
200 Ft. Meade Rd - Laurel, Md. 20810 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 8, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert McCreedy | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02696 | | | |
|--|--|-------------------------|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
VINCENT J. WINTERMYER, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
Jan 29 1981 | | 2b. HOUR
1057 PM | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Jul 3 25 55 | | 6. AGE (IN YEARS) (LAST MONTH-DAY) YRS.
25 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
Jan 29 1981 | | 2d. HOUR
1057 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
511 Spg. | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp Silver Spring Md | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov. | |
| 13a. STATE MD 13b. COUNTY Mont 13c. CITY OR TOWN Silver Spg | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2011 Forest Hill Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Vincent J. Wintermyer | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Heleen Spahn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
yes | | | | 16b. SOCIAL SECURITY NO.
WWII 578 22 5684 | | | | 17. INFORMANT 2011 Forest Hill Dr. SS. Md. Geraldine Wintermyer (wife) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction
4291 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | TITLE (SPECIFY) MD. | | | | DATE SIGNED Jan 30 1981 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, MD. | | | | ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Feb. 2, 1981 | | 23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Taltavull Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR FEB 5 1981 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |
| 4748 Wisc. Ave. N.W. Wash. D.C. 20016 | | | | | | | | | | | | | |

WASHINGTON, D.C. USA
11th Nov. 1961
11th Nov. 1961

Vincent J. Wintermyer
11th Nov. 1961
11th Nov. 1961

John F. Kennedy, Jr.
11th Nov. 1961
11th Nov. 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8102697
REG. NO. | | | | | |
|--|--|--|--|---|--|--|--|--|----------------------------------|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) KATHERINE V WITTE | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 3, 1981 | | | | 2b. HOUR
6:10 P.M. | |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 30, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. UNFILL 1 YEAR
MONTHS DAYS
82 | | 8. UNFILL 24 HRS
HOURS MIN.
6:10 P.M. | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | | | |
| 13. CITY OR TOWN OF DEATH
GAITHERSBURG | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 15. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TELEPHONE OPERATOR - TELEPHONE | | | 16. KIND OF BUSINESS OR INDUSTRY | | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
17a. STATE Maryland 17b. COUNTY Montgomery 17c. CITY OR TOWN Rockville | | | | 18. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 19. STREET ADDRESS
9701 VIERS Mill DR. | | | | | | | |
| 20. FATHER'S NAME
FIRST MIDDLE LAST
HENRY SCHOELKOPF | | | | 21. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VICTORIA WOLFF | | | | | | | | | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO NONE | | | | 23. SOCIAL SECURITY NO.
579247932 | | 24. INFORMANT ADDRESS
REV. DR. RICHARD REICHARD - 9701-VEIRS DR., ROCKVILLE, MD. | | | | | | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4860 IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) 1 week | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 26a. DATE OF OPERATION | | | | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 26c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 26d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 27b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 28a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 28b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 28c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 29. I certify that (I) (this hospital) attended the deceased from 12-30 19 80 , to 1-1 19 81 , that (I) (we) last saw the deceased alive on 1-1 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 29b. SIGNATURE
Harold F. McCann, M.D. | | | | | | | | DEGREE
M.D. | | 29c. DATE SIGNED
1-5-81 | | | |
| 29d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | | | | | | | 29e. ADDRESS
3355-16th St. N.W. WASH. D.C. 20010 | | | | | |
| 30a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 30b. DATE
JAN, 7, 1981 | | 30c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEMETERY | | 30d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | | | |
| 31. FUNERAL DIRECTOR
NAME ADDRESS
HYSONG CO. - 1300- N ST., NW WASH., D.C. | | | | | | | | 32. DATE REC'D. BY REGISTRAR 32b. REGISTRAR'S SIGNATURE
JAN 14 1981 | | | | | |

BP

WITTE

A.B.

U.S. MAR

1911

1911

1911

X

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 9 8

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Maurice | | | FIRST MIDDLE LAST Wood | | | 1a. DATE OF DEATH MONTH DAY YEAR 1/10/81 | | | 2a. HOUR 6:10 P.M. | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR 07 22 1891 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Silver Spring | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab Worker | | | 12b. KIND OF BUSINESS OR INDUSTRY Gen. Refractory | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel C Wood | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ireland | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 215-05-7669 | | |
| 17. INFORMANT ADDRESS Rt. 2, Box F3713 | | | 18. NAME OF INFORMANT Elizabeth M. Liesemann-Harwood, Md. | | | 19. DATE OF DEATH 1-10-81 | | | 20. TIME OF DEATH 10/80 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Influenza
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia RUL & RML
DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Malnutrition, COPD, Bronchiectasis, ASCVD, Renal Insufficiency | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | 21g. I certify that (I) (this hospital) attended the deceased from 3-0-79 19 to 1-10-81 19, that (I) (we) last saw the deceased alive on 1-6-81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22a. SIGNATURE G B Patrick II MD | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick II MD | | | 22c. ADDRESS 4221 Colesville Rd Silver Spring, Md 20910 | | | 22d. DATE SIGNED 1-10-81 | | | 22e. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/13/81 | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | 24b. ADDRESS 7401 Belair Road | | | 25a. DATE RECEIVED BY REGISTRAR 1-10-81 | | | 25b. REGISTRAR'S SIGNATURE | | |

ST. LOUIS, MO.

1907

1907

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3, by the health department, and page 4, 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 2 6 9 9

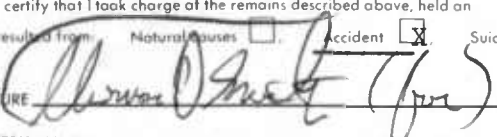
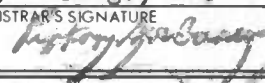
REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Pearl A Wright | | | 2a DATE OF DEATH
MONTH DAY YEAR Jan 26-81 | | | 2b HOUR
6:45 A | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR 8-13-89 | | 6 AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
501 PIPING ROCK DRIVE | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | | |
| 13a STATE
MARYLAND | | | 13b COUNTY
MONTGOMERY | | 13c CITY OR TOWN
SILVER SPRING | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
501 PIPING ROCK DRIVE | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
WILTON | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANN LLOYD | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b SOCIAL SECURITY NO.
577-20-7542 | | 17 INFORMANT
MARIE W. WENDT | | ADDRESS
SAME AS 13 | | DAUGHTER | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(b) arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) chronic Congestive Failure
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4140
years | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from May 8 19 74 to 1-26 19 81 , that (I) (we) last saw the deceased alive on 12-19 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
George J. Mishtowt, MD | | | | | | DEGREE
MD | | 22c DATE SIGNED
1-26-81 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE I. MISHTOWT | | | | | | 22e ADDRESS
CHEVY CHASE MONTGOMERY MARYLAND | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b DATE
1/28/81 | | 23c NAME OF CEMETERY OR CREMATORY
GLENWOOD CEMETERY | | 23d LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON, D. C. | | | |
| 24 FUNERAL DIRECTOR
NAME F RANCIS J. COLLINS
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a DATE REC'D. BY REGISTRAR
JAN 27 1981 | | 25b REGISTRAR'S SIGNATURE
Richard A. Brady | | |

M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | | | | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 02700 | |
|--|--|----------------------------------|--|--|--|---|--|---|--|---|--|---|--|--|-----------------------------------|--|----------------------|--|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DIANA L. WYMAN | | | | | | | | | | 2b. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 18 19 81 | | | | | 2d. HOUR M | | | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR Nov. 7, 1959 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 21 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 1 18 19 81 | | | | | 2d. HOUR 3a M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Commercial Artist | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
26116 Cornor Dr. | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harold L. Wyman | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlen L. Henne | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
219-82-2056 | | 17. INFORMANT ADDRESS
Harold L. Wyman, Item 13 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8150
IMMEDIATE CAUSE (a) Cranio-cerebral trauma
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:25 PM 1-18- 1981 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver in auto/fixed object impact. | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 108 Damascus Montgomery Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED 1-19-81 | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Jan. 22, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Montg., Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A. | | | | ADDRESS
Damascus, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1981 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | | |

1951

General Information

and Special

Notes

and

Remarks

Page

of

10

10

10-10-10

10-10-10

10-10-10

(Handwritten signature)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8102701

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|--|---|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Emily Zugibe Yadgi | | | 2a DATE OF DEATH
MONTH DAY YEAR
February 31, 1981 | | 2b HOUR
2309 AM | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
Aug. 30, 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a STATE
Virginia | | 13b COUNTY
Fairfax | | 13c CITY OR TOWN
Falls Church | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Constantine --- Zugibe | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Asma --- Saadi | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No --- | | |
| 16b SOCIAL SECURITY NO.
227-70-7046 | | 17 INFORMANT
ADDRESS
Albert S. Yadgi, Same address as # 13. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Carlinomites</u>
<u>1579</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>Carlinomites</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>1 year</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1-2 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Ca 2 breast</u> | | | | | | |
| 19a DATE OF OPERATION
<u>March 80</u> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Ca pancreas</u> | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1/30</u> 19 <u>81</u> , to <u>1/31</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> 19 <u>81</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | |
| 22b SIGNATURE
<u>M. E. K. ALON</u> | | DEGREE | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
<u>1/31/81</u> |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>M. E. K. ALON</u> | | 22e ADDRESS
<u>3915 Franklin Dr. Wheaton, Md</u> | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b DATE
<u>2/3/81</u> | | 23c NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | 23d LOCATION
CITY OR TOWN COUNTY STATE
<u>Washington, D.C.</u> |
| 24 FUNERAL DIRECTOR
NAME
<u>Joseph Gawler's Sons, Inc.</u> | | | | 25 DATE REC'D BY REGISTRAR
<u>FEB 4 1981</u> | | |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | 25b REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

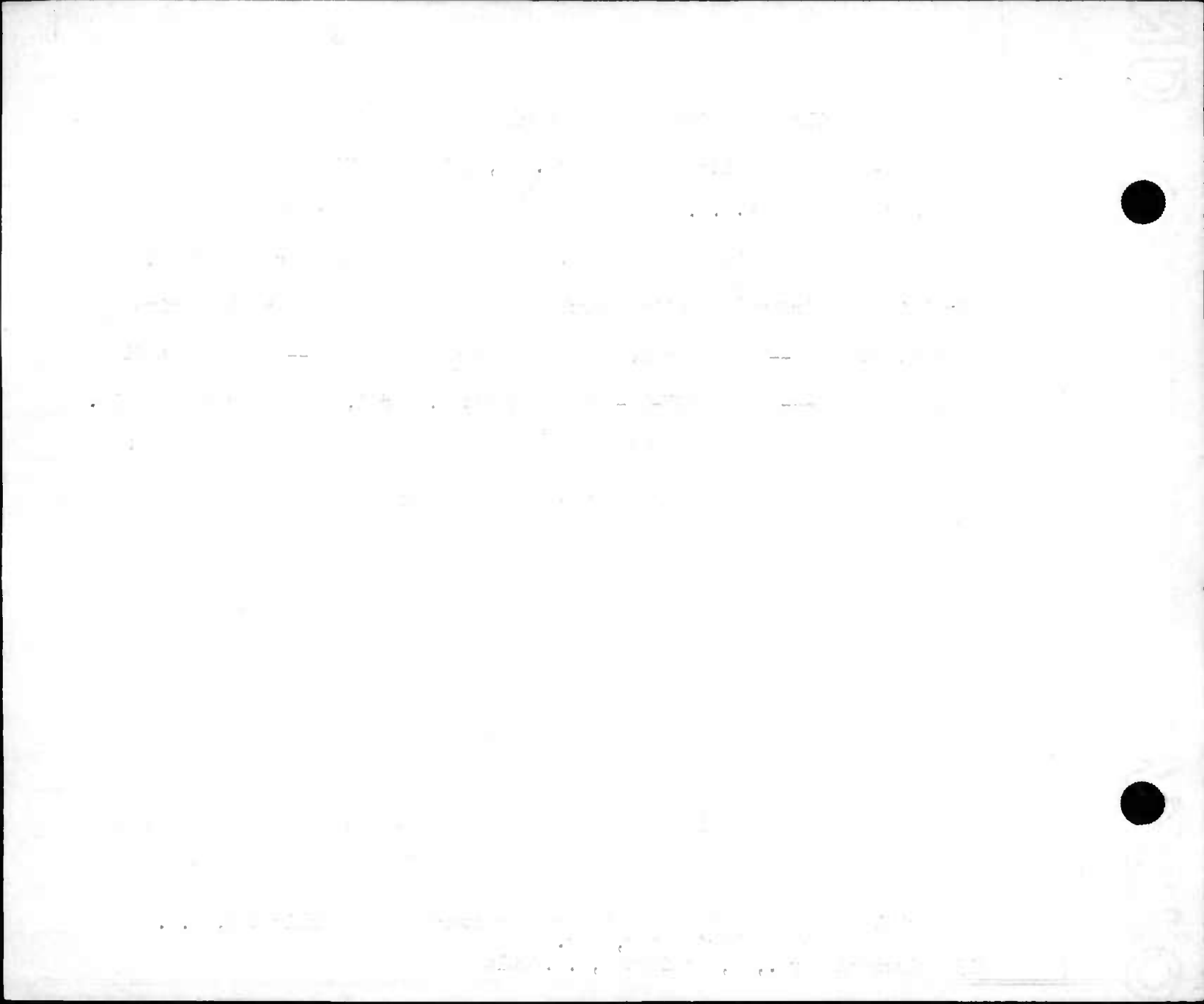
BP

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 81 02702 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) Wilbert P. Young | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 25 81 | | 2b. HOUR
MIN
10 40 PM | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 3, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 8. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery county | | 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
Md. | | 13b. COUNTY
Montg. | |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3509 Norbeck Rd. | | 14. FATHER'S NAME
FIRST MIDDLE LAST
David Young, Sr. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David Young, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mollie Pugh | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-30-4939 | | 17. INFORMANT
ADDRESS
Ruby Young (wife) same as #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Ischemic Deposition - uremia - asbestosis - anasarca | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Ischemic Deposition - uremia - asbestosis - anasarca | | 19a. DATE OF OPERATION
25 Jan 81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ischemic Deposition - uremia - asbestosis - anasarca | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 19 74 to 25 Jan 81 , that (I) (we) lost the deceased alive on 25 Jan 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | |
| 22a. SIGNATURE
Merton L. White M.D. | | 22b. DEGREE
M.D. | | 22c. DATE SIGNED
26 Jan 81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Merton L. WHITE, M.D. | | 22e. ADDRESS
9911 Georgia Ave S, Silver Spring Md | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1-31-81 | | 23c. NAME OF CEMETERY OR CREMATORY
DAISY Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DAISY Howard Md. | | 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | 25a. DATE REC'D. BY REGISTRAR
JAN 30 1981 | | 25b. REGISTRAR'S SIGNATURE
Robert H. Young | | 25c. REGISTRAR'S SIGNATURE
Robert H. Young | | 25d. REGISTRAR'S SIGNATURE
Robert H. Young | | 25e. REGISTRAR'S SIGNATURE
Robert H. Young | |



JAN 30 1981

Handwritten signature or initials.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8102703
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rita Rita Zaltzman | | 2a. DATE OF DEATH
MONTH DAY YEAR
JANUARY 11 - 1981 | | 2b. HOUR
8:30 AM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 17 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wash. Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Groupe Manager | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Hecht Co. | | 13a. STREET ADDRESS
10112--52nd Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Josef Geringer | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresia Auer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-54-5938 | | 17. INFORMANT
Irving Zaltzman Husband. Same as item 13. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>inaction</u>
<u>1890</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic hypernephroma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 1980</u> to <u>Jan 10 1981</u> , that (I) (we) last saw the deceased alive on <u>Jan 10 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DJ HAIDAK | | 22e. ADDRESS
Belcrest Rd. Hyattsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1/13/1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1/15/1981

April 17 1980
XX
U.S.A.
Postmaster

Mr. Prince George College and
10115--22nd Ave.
Group, University
Health Co.

Joseph
115-8-708
Livingston, New Jersey
New

7150 Wisc. Ave., N.W. Wash., D.C.
Joseph Lawrence's son Inc.
1/15/1981 Cedar Hill Crematory
JAN 15 1981
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8102704 | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WANDA 24 BACZINSKI | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR
1/16/81 11:15 AM | |
| 3. SEX
Female | | 4. RACE
POLISH | | 5. DATE OF BIRTH MONTH DAY YEAR
Aug. 29, 1896 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
Italy | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
84 YRS. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kensington Gardens Nursing Home | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | |
| 13a. STATE
MD. | | 13b. COUNTY
Wash. D.C. | | 13c. CITY OR TOWN
Wash. D.C. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Giovanna De-Muratti De-Guiseppe | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Warren M. Robbins 530 6th St. S.E. Wash. D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4140
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 29, 1979 to 1/16/81 that (I) (we) last saw the deceased alive on 1/16/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Thos G. Ward | | DEGREE
MD | | 22c. DATE SIGNED
1/16/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Ward | | 22e. ADDRESS
6116 Robinwood, Bethesda, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Donation Removal | | 23b. DATE
Jan. 16, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Anatomical Board | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington D.C. | | 23e. DATE REC'D BY REGISTRAR
JAN 26 1981 | | | |
| 24. FUNERAL DIRECTOR NAME
Columbia Mortuary Service | | ADDRESS
4748 Wisc. Ave N.W. Wash. D.C. | | 25. REGISTRAR'S SIGNATURE
[Signature] | |

BP

